

95 11001

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERIC HOSIE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>372-42-8722</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 1, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SCOTLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>17 POWHURST COURT</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>17 POWHURST COURT</b>	
10f. ZIP CODE <b>21236</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BOARD OF DIRECTOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BANKING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>PETER FORDYCE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HOSIE ANNE HEPBURN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CALVERT BREGEL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>BUNKER HILL FARM 4939 LONG GREEN RD. GLEN ARM, MD 21057</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP 4/11/95</b>		20c. LOCATION — City or Town, State <b>TOWSON, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> <b>JOHN E. DOLAN</b>				22. NAME AND ADDRESS OF FACILITY <b>RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF THE COLON</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Disease. Status Post CVA</b> <b>Atrial Fibrillation</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark M. Givley</i> <b>MARK M. GIVLEY</b>				29c. LICENSE NUMBER <b>RD 1520</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/10/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>MARK M. GIVLEY, Franklin Square Hospital, Baltimore, 21237.</b>							
31. REGISTERED (Month, Day, Year) <b>APR 11 1995</b> <i>John A. Russell</i> <b>JOHN A. RUSSELL</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





95 11002

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Juanita L. Horst				2. DATE OF DEATH April 11, 1995		3. TIME OF DEATH 9:00 A M	
4. SOCIAL SECURITY NUMBER 220-12-2906		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-11-1911	
9a. FACILITY NAME (If not institution, give street and number) 12618 Manor Road				9b. CITY, TOWN OR LOCATION OF DEATH Glen Arm		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Glen Arm	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 12618 Manor Road				10f. ZIP CODE 21057		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plant Worker		16b. KIND OF BUSINESS/INDUSTRY Allied Bendix, Corp.			
17. FATHER'S NAME (First, Middle, Last) Cebert Hash				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Ward			
19a. INFORMANT'S NAME (Type/Print) William H. Horst				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4421 Langtry Drive, Glen Arm, Maryland 21057			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wilson Methodist Cemetery 4-12-95		20c. LOCATION — City or Town, State Long Green, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S Brooks, Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardio Renal Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles F. O'Donnell, MD				29c. LICENSE NUMBER D-09383		29d. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell, MD - 111 Hamlet Ave. APT 408 Baltimore Md 21210							
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE John A. [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11003

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT MELVIN HEER, Sr.				2. DATE OF DEATH MONTH DAY YEAR April 5 1995		3. TIME OF DEATH 5:14 p.m.	
4. SOCIAL SECURITY NUMBER 212-26-1369		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-11-30	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland			
10b. COUNTY Harford				10c. CITY, TOWN OR LOCATION Jarrettsville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3623 Woodholme Dr.			
10f. ZIP CODE 21084				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Engineer		16b. KIND OF BUSINESS/INDUSTRY Engineering			
17. FATHER'S NAME (First, Middle, Last) Wilmer Jacob Heer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Freida Hornig			
19a. INFORMANT'S NAME (Type/Print) Maria C. Heer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 Woodholme Dr. Jarrettsville, Md. 21084			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 4-10		20c. LOCATION — City or Town, State Towson, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>CONGESTIVE HEART FAILURE</u>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. <u>ACUTE PULMONARY</u>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. <u>ACUTE VALVE DISEASE</u>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ischemic Heart Disease</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <u>Not Applicable</u>					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D1875B		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Gross M.D. 50 Scott Adam Rd. Suite 101 Cockeysville, Md.							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM GARFIELD HARVEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>238 32 9285</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/23/27</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>VA MEDICAL CENTER</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>FORT HOWARD</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7972 Knoll Park Court Apt. 104</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>Chipper and Caulker</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Shipyard</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Shipyard</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Willard Harvey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katie England</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Vera Lowe</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7987 Knoll Park Ct. Apt 203 Glen Burnie, Md. 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore National Cem. 4/11</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>PERIPHERAL VASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raul Rivera</i>				29c. LICENSE NUMBER <b>D45788</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-9-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Raul Rivera, M.D. -- 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11005

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELSIE I. HOOVER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:36 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-54-3350</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-20-1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>COCKEYSVILLE</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>13801 YORK RD.</b>	
10f. ZIP CODE <b>21030</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOMEMAKER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>FRANKLIN A. WRIGHT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH H. BUCK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SAMUEL H. HOOVER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13801 YORK RD. c-7 COCKEYSVILLE, MD. 21030.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY 4/95</b>		20c. LOCATION — City or Town, State <b>PARKVILLE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. Davis III</i>				22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHRONIC ANEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENCIA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. W. [Signature]</i>				29c. LICENSE NUMBER <b>D33011</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R H WICKERFELD 3346 PARKMILL Rd PHOENIX Md 21131</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDA JACOBSON</b>		2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 6 1995</b>		3. TIME OF DEATH <b>830 A</b>	
4. SOCIAL SECURITY NUMBER <b>213-34-4785</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>APR. 17, 1908</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>OWINGS MILLS</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10 DEERLIDGE CT., APT. C</b>		10f. ZIP CODE <b>21117</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN POTLER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY LITVINSKY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. CARL SACKS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>R.R.#1, BOX 230-L THOMASVILLE, PA 17364</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH TFILOH 4/7/1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>Coronary artery failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Demencia</b>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D27123</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Judith Hinkov 750 Main ST Renton mo 21131</b>					
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10




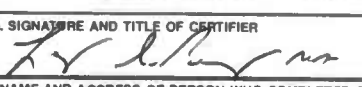
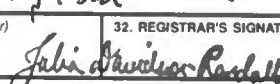
2021/1/1



95 11007

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DELLA JOYNER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 03 1995</b>		3. TIME OF DEATH <b>8:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>238-66-3247</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 15, 1941</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>34 N. Poppleton Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>34 N. Poppleton Street</b>	
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>DISABLE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>	
17. FATHER'S NAME (First, Middle, Last) <b>CEASAR D. MERRITT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAYO MERRITT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOHN MERRITT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2324 DRUID HILL AVENUE BALTIMORE, MARYLAND 21217</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL 4/8</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Artery with</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Spasm</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Pulmonary Hypertension</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1st Aneurysm resection</b> <b>Ribcage</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>122031</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-4-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2116 Maryland Ave Baltimore 21214</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11008

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ruth L. Johannesen</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-18-6483</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1908</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8107C Glen Hollow Drive</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Medical Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Health Care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Madison Wheeler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne Elizabeth Kruhm</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernard G. Johannesen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8107C Glen Hollow Dr., Glen Burnie, Maryland 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery April 11, 1995</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E. Glen Burnie, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL HEMORRHAGE</b> Approximate Interval Between Onset and Death <b>12 DAYS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>ATRIAL FIBRILLATION</b> years c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>ABOSMA MD HOUSE - STAFF</b>					
29c. LICENSE NUMBER <b>A46551</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 8, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GUARI A. OSMA MD 2407F NORMANBY RD PL MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine Louise Johnson</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 07 95</i>		3. TIME OF DEATH <i>9:55 A M</i>		
4. SOCIAL SECURITY NUMBER <i>215-01-9239</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>91</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6/4/03</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>GOOD SAMARITAN HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>		9c. COUNTY OF DEATH <i>N/A</i>		
RESIDENCE OF DECEDENT								
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>2103 MAISEL STREET</i>				10f. ZIP CODE <i>21230</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>7th GRADE</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>				
17. FATHER'S NAME (First, Middle, Last) <i>FRANK WOLF</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LOUISE HANUS</i>				
19a. INFORMANT'S NAME (Type/Print) <i>MARY HAMMEL</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8365 HILLEDALE ROAD BALTIMORE, MD 21234</i>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>NEW CATHEDRAL CEMETERY 4/10/95 BALTIMORE, MD</i>		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</i>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Ischemic heart Disease</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>IBP</i>							Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard Bond M.D.</i>				29c. LICENSE NUMBER <i>D19793</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/8/95</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Howard Bond M.D. 9618 Belair Road Baltimore, MD 21236</i>								
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ARTHUR JONES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 04 95</b>		3. TIME OF DEATH <b>1:11 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 29, 1936</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1941 N. PATEE PATTERSON PARK AVENUE</b>	
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>7 TH</b> College (1-4 or 5+) <b>-</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>JANITORIAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AQUA CLEANER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CLYDE JONES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NELLIE SCOTT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CALVIN JONES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>831 N. LUZERNE AVENUE, BALTIMORE, MD 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHELL MEMORIAL GARDENS 4-10</b>		20c. LOCATION — City or Town, State <b>DUNDALK, MARYLAND</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AE.</b>			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Blunt force injuries to head with complications</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>4-1-95</b>		28b. TIME OF INJURY <b>unknown</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject struck</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1941 N. Patterson Park Ave Baltimore</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 5, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11011

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Shirley M. Justice</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 6, 1995</i>		3. TIME OF DEATH <i>1058 A M</i>	
4. SOCIAL SECURITY NUMBER <i>223-30-6208</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>67</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 10, 1927</i>	
8. BIRTHPLACE (State or Foreign Country) <i>New York</i>				9a. FACILITY NAME (If not institution, give street and number) <i>University Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Baltimore City</i>				RESIDENCE OF DECEDENT			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Carroll County</i>		10c. CITY, TOWN OR LOCATION <i>Sykesville</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6401 Church Street</i>				10f. ZIP CODE <i>21784</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nurse</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Health Care</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Earl H. Joyner</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mabel Chapman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. James L. Justice</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6401 Church Street Sykesville, MD 21784</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lake View Mem. Park</i>		DATE <i>4/10/95</i>		20c. LOCATION — City or Town, State <i>Sykesville, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian D. Haight</i>				22. NAME AND ADDRESS OF FACILITY <i>HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Hemorrhage</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Pulmonary Hemorrhage</i> b. <i>Ruptured pulmonary artery during Swan ganz insertion</i> c. <i>Swan ganz insertion</i> d. <i>D.C. APPROVED OCME</i>							Approximate Interval Between Onset and Death <i>One hour</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Frontal Meningioma</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>4-6-95</i>		28b. TIME OF INJURY <i>10 A M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>Catheter ruptured an artery</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Hospital</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>University Hospital Baltimore, MD</i>			
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>April 6, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Arthur J. DiPatri MD, 22 South Greene Street Balt. MD 21201</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11012

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAULINE JOHNSON</b>				2. DATE OF DEATH <b>APRIL 7, 1995</b> MONTH DAY YEAR		3. TIME OF DEATH <b>1430</b> M	
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 1, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1008 MC ALEER COURT</b>	
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 TH</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOMESTIC</b>		16b. KIND OF BUSINESS/INDUSTRY <b>housewife</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIE BOYD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIRGINIA BOYD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HUBBARD TANN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1020 MC ALEER COURT, BALTIMORE, MD 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL GARDENS 4-13 DUNDALK, MD</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lee V. Holland</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Asoxic Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>4 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aspiration Pneumonia</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Navarro Med-Specialist</b>				29c. LICENSE NUMBER <b>D40356</b>		29d. DATE SIGNED <b>APRIL 7, 1995</b> <b>MARCH 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N. NAVARRO 100 N. BROADWAY BALTIMORE, MD. 21231</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Hurdell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for medical purposes.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAHJ J. JORDAN				2. DATE OF DEATH MONTH DAY YEAR APRIL 06 1995		3. TIME OF DEATH 10:43 P M	
4. SOCIAL SECURITY NUMBER 212-06-5043		5. SEX X <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 20 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUL.12, 1974	
9a. FACILITY NAME (If not institution, give street and number) SHOCK TRAUMA CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? X <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5118 THE ALAMEDA				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS X <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES: XX		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) 3 YEARS		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT		15b. KIND OF BUSINESS/INDUSTRY MORGAN STATE UNIVERSITY			
17. FATHER'S NAME (First, Middle, Last) REGINALD JORDAN				16. MOTHER'S NAME (First, Middle, Maiden Surname) DEBORAH POWELL			
19a. INFORMANT'S NAME (Type/Print) REGINALD JORDAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5118 THE ALAMEDA, BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA V CEM. 4-14 OWINGS MILLS, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lee V. Holland				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4 6 95		28b. TIME OF INJURY A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND ON STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2400 BAKER ST BALTIMORE MD	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Maurice DeYlue				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 07, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYSAVAN D. KOBEN 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used to obtain the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11014

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George Albert Jackson, Jr</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2015 M</b>	
4. SOCIAL SECURITY NUMBER <b>215-12-4361</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/22/23</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>AA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>8010 Corksberry Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>AA</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>	
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO				10e. STREET AND NUMBER <b>8010 Corksberry Ln. Apt. 408</b>			
10f. ZIP CODE <b>21122</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES <b>1941-1945</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Guard</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Public Security</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Albert Jackson, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Powers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Diane Sandra Boeckmann</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>242 Wanda Rd. Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b>	
22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc.</b>		22. ADDRESS OF FACILITY <b>299 Frederick Rd. Baltimore, MD 21228</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>3</b> Suicide <b>6</b> Could not be determined <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William R. Jones Deputy</b>				29c. LICENSE NUMBER <b>D06054</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones, M.D. 695 America 21035</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jabir Al-Hussaini</b>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>Luther Clark Justis</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>				3. TIME OF DEATH <b>7:10 AM</b>					
4. SOCIAL SECURITY NUMBER <b>214-03-9921</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>July 12, 1895</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Charlestown Care Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>711 Maiden Choice Lane</b>						10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW I</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Furniture Co. - Retail</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Luther H. Justis</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>" Unknown " Cummings</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Robert G. Justis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>327 Old Trail Rd. Baltimore, MD 21212</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/11/95</b>				20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <b>Dementia</b>												Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Sharon J. McCormack MD</b>						29c. LICENSE NUMBER <b>D38762</b>				29d. DATE SIGNED (Month, Day, Year) <b>04/10/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sharon J. McCormack, MD. 711 Maiden Choice Lane Baltimore, MD 21228</b>													
31. DATE SIGNED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE  <b>John A. Russell</b>									



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jean Kent</i> JENNIE KENT				2. DATE OF DEATH MONTH <i>4</i> DAY <i>4</i> YEAR <i>95</i>		3. TIME OF DEATH <i>7:03 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-03-9481</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>DEC. 21, 1908</i>	
9a. FACILITY NAME (If not institution, give street and number) BAYVIEW MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>277 GERMAN HILL ROAD</i> <i>227</i>				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>6</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) LEVI COHEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA RHEINIS			
19a. INFORMANT'S NAME (Type/Print) MR. LENARD FELDMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3903 CARTHAGE RD. RANDALLSTOWN, MD 21133			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RIGA KURLANDER VEREIN		20c. LOCATION — City or Town, State 4-6-1995 ROSEDALE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wesley Levinson</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Bradycardia &amp; Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Multiple Myocardial Infarctions</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> <i>Probable Pulmonary Embolus</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard Ian Savage MD</i>				29c. LICENSE NUMBER 95013		29d. DATE SIGNED (Month, Day, Year) <i>4/4/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOWARD IAN SAVAGE, MD JHBM 494C Eastern Ave.							
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE <i>Jane D. K. K. K.</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED 1952

95 11017

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jay Michael Kallinsky</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5 1995</b>		3. TIME OF DEATH <b>2:12 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579 58 7248</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 4 1943</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Wheaton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>12014 Berry Street</b>	
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cab Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Kallinsky</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eleanor Manheim</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Fran Tettelbaum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5800 Wilmet Road Bethesda, MD 20817</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Mem. Gdns. 4/6 Falls Church, VA.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Ives Pearson Funeral Homes Falls Church, Virginia 22046</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ventricular Fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death <b>18 hours</b> <b>Several years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank N. Grayino, MD</i>				29c. LICENSE NUMBER <b>D25080</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frank N Grayino, 10313 Georgia Ave, Silver Spring, MD 20902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-1959031

blh ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/5/95 t.t

ITEM: 11. PER F.H. FILM G-722 4/11/95 t.t

95 11018

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert M. Klingensmith, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 07 1995</b>		3. TIME OF DEATH <b>0438</b>	
4. SOCIAL SECURITY NUMBER <b>204-54-8062</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>30</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 28, 1964</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5700 Chapman Mill Dr.</b>	
10f. ZIP CODE <b>20850</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HVAC Maintenance Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Building Maintenance</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert M. Klingensmith, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Shirley Carter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cynthia J. O'Leary</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>129 7th Street, Turtle Creek, Pa. 15145</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Homewood Cemetery</b>		20c. LOCATION — City or Town, State <b>Pittsburgh, Pa.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STABWOUND OF CHEST</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 4/7/95</b>		28b. TIME OF INJURY <b>4:10 A M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT STABBED SELF</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>5700 CHAPMAN MILL DR. BETHESDA, MD.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret D. White</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 07 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margaret D. White 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE SIGNED (Month, Day, Year) <b>April 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>DOROTHY KEIL</u> Dorothy Ruth Keil				2. DATE OF DEATH MONTH <u>4</u> DAY <u>9</u> YEAR <u>95</u>		3. TIME OF DEATH <u>23-55</u> M	
4. SOCIAL SECURITY NUMBER <u>216 10 2235</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>85</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 4, 1909</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N.A.</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>N.A.</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>3615 - 6th Street</u>			
10f. ZIP CODE <u>21225</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>9th</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Worker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Diamond Label Co.</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Charles Keil</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Augusta Eichhorst</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Leona Burrows</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3809 - 8th Street Baltimore, Maryland 21225</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>		20d. DATE <u>4/10</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Donna M. Zramisewski</u>				22. NAME AND ADDRESS OF FACILITY <u>George J. Gonce Funeral Home P.A.</u> <u>4001 Ritchie Hwy. Baltimore, Md. 21225</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u>							
Due to (or as a consequence of):							
b. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
Due to (or as a consequence of):							
c. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							
Due to (or as a consequence of):							
d. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Vasanthan - P. P.</u>				29c. LICENSE NUMBER <u>AS244161436</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/10/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>VASANTHAN. P. P. WABOOK HOSPITAL CENTER</u>							
31. DATE FILED (Month, Day, Year) <u>APR 11 1995</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11020

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lynford Harris LLOYD				2. DATE OF DEATH MONTH DAY YEAR April 7 1995		3. TIME OF DEATH 3:10 A M	
4. SOCIAL SECURITY NUMBER 207-03-8972		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1915	8. BIRTHPLACE (State or Foreign Country) PA.		
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3134 Wallford Drive				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Millwright		16b. KIND OF BUSINESS/INDUSTRY Steel Plant			
17. FATHER'S NAME (First, Middle, Last) Lynford H. Lloyd Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen R. Roughedge			
19a. INFORMANT'S NAME (Type/Print) Dorothy Lloyd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3134 Wallford Drive, Balto. Md. 21222			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MetroCrematory Inc. 4/8/95		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connelly</i>				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2-3 weeks 3 years							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2-3 weeks 3 years							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2-3 weeks 3 years							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2-3 weeks 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Randolph DeCarlo M.D.</i>				29c. LICENSE NUMBER D44918		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Randolph DeCarlo M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE <i>John Dawson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11021

Item 10f, g-722,4-11-95, per f.h.,dk

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACIE LEWIS</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>6</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:25P</b> M	
4. SOCIAL SECURITY NUMBER <b>218-22-6807</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/1/29</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>VA MEDICAL CENTER, FORT HOWARD, MD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FORT HOWARD</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>PASADENA</b>	
10e. STREET AND NUMBER <b>185 MOUNTAIN ROAD</b>				10f. ZIP CODE <b>21222-21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 TH</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT LEWIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ORA WALKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLARETTA WALKER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>191 MOUNTAIN ROAD, PASADENA, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST V A CEM. 4-12 OWINGS MILLS, MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph E. Pineda</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>LUNG CA</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rubén Reider M.D.</i>				29c. LICENSE NUMBER <b>D-22609</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-7-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RUBEN REIDER, MD, 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11022

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ANNA LOW</b>				2. DATE OF DEATH MONTH <b>4</b> / DAY <b>5</b> / YEAR <b>1995</b>		3. TIME OF DEATH <b>5:37 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-12-3188-D</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 22, 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>201 NORTH WASHINGTON STREET</b>			
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PASTOR ALBERTUS MARTIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2018 GREENMOUNT AVENUE, BALTIMORE, MARYLAND 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. LOCATION — City or Town, State <b>4-11-95 BALTIMORE, MARYLAND</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Brainstem CVA</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ASCVD</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Insulin Dependent Diabetes Mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 26594</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Church Home Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11023

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ernest L. Lowenbach				2. DATE OF DEATH MONTH March DAY 30, YEAR 1995		3. TIME OF DEATH 6:45 P. M.	
4. SOCIAL SECURITY NUMBER 577-22-4157		5. SEX XX M 2 F	6. AGE (In yrs. last birthday) 93 YRS.	7. DATE OF BIRTH MONTH July DAY 26, YEAR 1901	8. BIRTHPLACE (State or Foreign Country) Germany		
9a. FACILITY NAME (If not institution, give street and number) 622 Kenbrook Drive				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? XX YES 2 NO			
10e. STREET AND NUMBER 622 Kenbrook Drive				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married XX Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES XX NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant/Owner		16b. KIND OF BUSINESS/INDUSTRY Grocer			
17. FATHER'S NAME (First, Middle, Last) Leo Lowenbach				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hanna Lieblich			
19a. INFORMANT'S NAME (Type/Print) Fred Lowenbach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11450 Rowley Road, Clarksville, Maryland 21029			
20a. METHOD OF DISPOSITION XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Garden April 30, 1995		20c. LOCATION — City or Town, State Falls Church, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottmeyer				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 Carroll Street, N. W., Washington, D. C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH X Natural 5 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Penny L. Bisk, M. D.		29c. LICENSE NUMBER 120081		29d. DATE SIGNED (Month, Day, Year) 3/31/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Penny L. Bisk, M. D. 10313 Georgia Avenue, # 209, Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IF THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11024

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>HARRY Edward LINTHICUM</i>				2. DATE OF DEATH MONTH <i>APRIL</i> DAY <i>6</i> YEAR <i>95</i>		3. TIME OF DEATH <i>4:35 A M</i>	
4. SOCIAL SECURITY NUMBER <i>201-05-0010</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 5, 1909</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Bon Secours Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>309 S. Furrow St.</i>				10f. ZIP CODE <i>21223</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unobtainable</i> College (1-4 or 5+) <i>Gardener</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Gardener</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Dickeyville Institution</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Harry B. Linthicum</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Madeline Rosanna Williams</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Susan M. Wilkinson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>317 S. Furrow St., Balto., Md. 21223</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>		DATE <i>4/11</i>		20c. LOCATION — City or Town, State <i>Lansdowne, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <i>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis (Recurrent)</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. <i>Acute Congestive Heart Failure</i> <span style="float: right;">Approximate Interval Between Onset and Death <i>2 1/2 months</i></span> b. <i>Acute Renal Failure</i> <span style="float: right;"><i>2 1/2 months</i></span> c. <i>Recurrent Pneumonitis</i> <span style="float: right;"><i>2 months</i></span> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Urinary Tract Infection</i> <i>Malignant with Chronic Anemia</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D18711</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/6/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Bernardo V. Gonzalez Jr., MD - 2001 W. Baltimore St. Balto Md 21223</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles LeBon</u> CHARLES L. LeBON				2. DATE OF DEATH MONTH DAY YEAR <u>April 7 1995</u>		3. TIME OF DEATH <u>6:38 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>214-16-0756</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	8. AGE (In yrs. last birthday) <u>78</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <u>September 30, 1916</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N/A</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Md.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Halethorpe</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1944 Bell Avenue</u>				10f. ZIP CODE <u>21227</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>N/A</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Press Operator</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Kaiser Aluminum</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Charles LeBon</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna J. Quanot</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Barley LeBon</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1944 Bell Avenue, Halethorpe, Md. 21227</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Meadowridge Memorial Park</u> <u>4/11</u>		20c. LOCATION — City or Town, State <u>Elkridge, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Gary L. Kaufman</u>				22. NAME AND ADDRESS OF FACILITY <u>Gary L. Kaufman Funeral Home of Elk., Inc.</u> <u>5695 Main St., Elkridge, Md. 21227</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>SEPSIS</u>					
		b. DUE TO (OR AS A CONSEQUENCE OF): <u>URINARY TRACT INFECTION</u>					
		c. DUE TO (OR AS A CONSEQUENCE OF): <u>CONGESTIVE HEART FAILURE</u>					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death <u>10 DAYS</u> <u>10 DAYS</u> <u>YEARS</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Vincent M. Muntz</u>		29c. LICENSE NUMBER <u>2065</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-7-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>VIPVT MANTADISON</u> <u>ST. AGNES HOSPITAL</u>							
31. DATE FILED (Month, Day, Year) <u>APR 11 1995</u>		32. REGISTRAR'S SIGNATURE <u>John A. Hurd</u>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-----

10/11/56

10/11/56



95 11026

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Allen P. Lewin</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-30-9676</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEP. 27, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Forest Haven Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>132 S. Gilmore Street</b>	
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Grocery Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard Lewin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bettie unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael Scott</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>132 S. Gilmore Street Balto. Md. 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 4-13-95</b>		20c. LOCATION — City or Town, State <b>Baltimore</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Phyllis Stacks</b>	
22. NAME AND ADDRESS OF FACILITY <b>Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. Md. 21228</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. end stage cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Harold B. Bob</b>				29c. LICENSE NUMBER <b>D15872</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Harold B. Bob 7220 Park Heights Ave 21208</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 11 11

APR 11 1951

asp

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KEITH LITTLE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 07 1995</b>		3. TIME OF DEATH <b>12:57 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-13-5263</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>23</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEP 14 1971</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL ER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>NA</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>NA</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>830 ALLENDALE ST.</b>	
10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>LABORER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FACTORY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES LITTLE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PEARLIE SALTGURY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES LITTLE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>830 ALLENDALE ST. BALT. MD. 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>NEW CATHEDRAL</b>		20c. LOCATION — City or Town, State <b>4-12-95 BALTIMORE MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>GARY E. MARSH FUNERAL HOME INC. 270 FREDERICK BLVD BALT. MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>HANGING</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SCHIZOPHRENIA STATUS POST GUNSHOT WOUNDS TO LOWER EXTREMITIES</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>4 7 95</b>		28b. TIME OF INJURY <b>A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>HANGED SELF</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>JAIL CELL</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>401 EAGER ST BALTIMORE MD</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 07, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARGARET D. KAPLAN 111 N. PENN ST. BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11028

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dangerfield Morris				2. DATE OF DEATH MONTH 4 - DAY 7 - YEAR 95		3. TIME OF DEATH 10:00 A.M.	
4. SOCIAL SECURITY NUMBER 215-12-3051		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 23, 1923	
8. BIRTHPLACE (State or Foreign Country) Va				9a. FACILITY NAME (If not institution, give street and number) 714 Brune St		9b. CITY, TOWN OR LOCATION OF DEATH Balto	
9c. COUNTY OF DEATH N/A				10a. STATE Md			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Balto			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 714 Brune St			
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th grade		15b. College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown		16b. KIND OF BUSINESS/INDUSTRY Unknown	
17. FATHER'S NAME (First, Middle, Last) Dangerfield Morris, Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susanna Coleman			
19a. INFORMANT'S NAME (Type/Print) Mary De Shazo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Walden Laurel Ct Balto, Md 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest 4/24/95		20c. LOCATION — City or Town, State Dwight Mills, Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March	
22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypoxia DUE TO (OR AS A CONSEQUENCE OF): b. Adenocarcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Immediate months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER S. Marshall				29c. LICENSE NUMBER D35363		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. Marshall MD BVAMC 10 N. Greene St. Baltimore, Md. 21201							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be completed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

104H



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Esther Melcher</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>7</i> YEAR <i>95</i>		3. TIME OF DEATH <i>11:55 A.M.</i>							
4. SOCIAL SECURITY NUMBER <i>213-26-9358</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>63</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12/20/31</i>							
8. BIRTHPLACE (State or Foreign Country) <i>Balto.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Bon Secours Hosp.</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto.</i>							
10a. STATE <i>Maryland</i>				10b. COUNTY <i>n/a</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>							
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1530 W. Lexington Street</i>		10f. ZIP CODE <i>21223</i>							
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES							
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>n/a</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>In Home</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Unknown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ruth Ferrell</i>									
19a. INFORMANT'S NAME (Type/Print) <i>Rev. Era S. Ferrell</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1530 W. Lexington St. Baltimore, Md. 21223</i>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Auburn Cemetery 4/12</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Geroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <i>GEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a. <i>Hypertensive coronary artery disease</i></td> <td>Approximate interval between Onset and Death <i>30 mins</i></td> </tr> <tr> <td>b. <i>Old Stroke</i></td> <td><i>5 years</i></td> </tr> <tr> <td>c. <i>Diabetes Mellitus, type II</i></td> <td><i>2 years</i></td> </tr> </table>								a. <i>Hypertensive coronary artery disease</i>	Approximate interval between Onset and Death <i>30 mins</i>	b. <i>Old Stroke</i>	<i>5 years</i>	c. <i>Diabetes Mellitus, type II</i>	<i>2 years</i>
a. <i>Hypertensive coronary artery disease</i>	Approximate interval between Onset and Death <i>30 mins</i>												
b. <i>Old Stroke</i>	<i>5 years</i>												
c. <i>Diabetes Mellitus, type II</i>	<i>2 years</i>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bernardo D. Gonzalez Jr.</i>				29c. LICENSE NUMBER <i>018711</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/8/95</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BERNARDO D. GONZALEZ JR., MD, - 2000 W. Belton, Balto, MD 21223</i>													
31. DATE OF DEATH (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21268

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2000 11 11



95 11030

ITEM: 8. PER F.H. FILM G-722 4/11/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sidney Meister</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 6 1995</b>		3. TIME OF DEATH <b>700 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-14-8341</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 17, 1924</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2500 W. BELVEDERE AVE, APT. 215</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII-ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STEAMFITTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STEEL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL MEISTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GUSSIE CHERNOFF</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. FAYE TOULAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8424 LUCERNE ROAD RANDALLSTOWN, MD 21133</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON -CHIZUK AMUNO 4-7-1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		20d. DATE <b>4-7-1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jay Lewis</b>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Massive Brain Infarct</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Diffuse cerebral vasculitis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia / GI Bleed</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>AD</b>				29c. LICENSE NUMBER <b>A52402321</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Diane T. Trickett DO Sinai Hosp Balt Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Shuster-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AKA ROSEMARIE FLORENCE MCGINNIS</b> <b>ROSEMARIE F. MCGINNIS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:55 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-40-5451</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 28, 1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>NA</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>NA</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore (Lakeland)</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2517 Southdene Avenue,</b>			
10f. ZIP CODE <b>21230</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Binder and Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Art Litho Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Gilbert Hester</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Rose Patti</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Sarah Rose Dehn</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4404 Fairhaven Ave., Baltimore, Md. 21226</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Pk. 4/12/95</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>		20d. DATE <b>4/12/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>METASTATIC LEIOMYOSARCOMA (TOLUNG) 1 YEAR</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 MONTH</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shab An. Wehba, house officer</b>				29c. LICENSE NUMBER <b>AS 2441614-26</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 9 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>I HAB M. WAHBA 3001 SOUTH HANOVER STREET, BALTIMORE MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julie Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


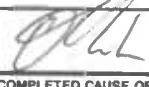

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NAOMI MACKINNON				2. DATE OF DEATH APRIL 4, 1995		3. TIME OF DEATH 2:33 P					
4. SOCIAL SECURITY NUMBER 219-12-6314		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 3, 1925		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) 4312 SPRINGDALE STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A				
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 4312 SPRINGDALE AVENUE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16. KIND OF BUSINESS/INDUSTRY UNKNOWN							
17. FATHER'S NAME (First, Middle, Last) PERRY LINDSAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET THOMAS							
19a. INFORMANT'S NAME (Type/Print) MARQUERITE WOODS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4312 SPRINGDALE AVENUE BALTIMORE, MARYLAND 21215							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK 4/10		20c. LOCATION — City or Town, State ARBUTUS, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sub arachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Ruptured cerebral aneurysm DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Partial		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 5, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

a

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11033

ITEMS: 1.9a,10c, PER F.H. FILM G-722 4/11/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>Robert Matthews</del> ROBERT MATTHEWS				2. DATE OF DEATH MONTH 4 DAY 6 YEAR 95		3. TIME OF DEATH 4:15P M	
4. SOCIAL SECURITY NUMBER 237-22-0070		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-27-22	
8. BIRTHPLACE (State or Foreign Country) UNK				9. FACILITY NAME (If not institution, give street) Harford Gardens Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH M/A				10. RESIDENCE OF DECEDENT			
10a. STATE MD.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4700 Harford RD.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) UNK.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNK.		16b. KIND OF BUSINESS/INDUSTRY UNK.	
17. FATHER'S NAME (First, Middle, Last) UNK.				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNK.			
19a. INFORMANT'S NAME (Type/Print) Alice Bellamy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 Park Ave. Balto. MD 21201			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cem. 4-8-95		20c. LOCATION — City or Town, State Lansdowne, MD.		20d. DATE 4-8-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H PA 638 N. Gilmor St. 21217			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction. DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION. DUE TO (OR AS A CONSEQUENCE OF): c. Brain Infarct. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D16188		29d. DATE SIGNED (Month, Day, Year) 4/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Walker Impaglatelli, M.D. 100 N Broadway Balto. 21231							
31. DATE OF DEATH (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

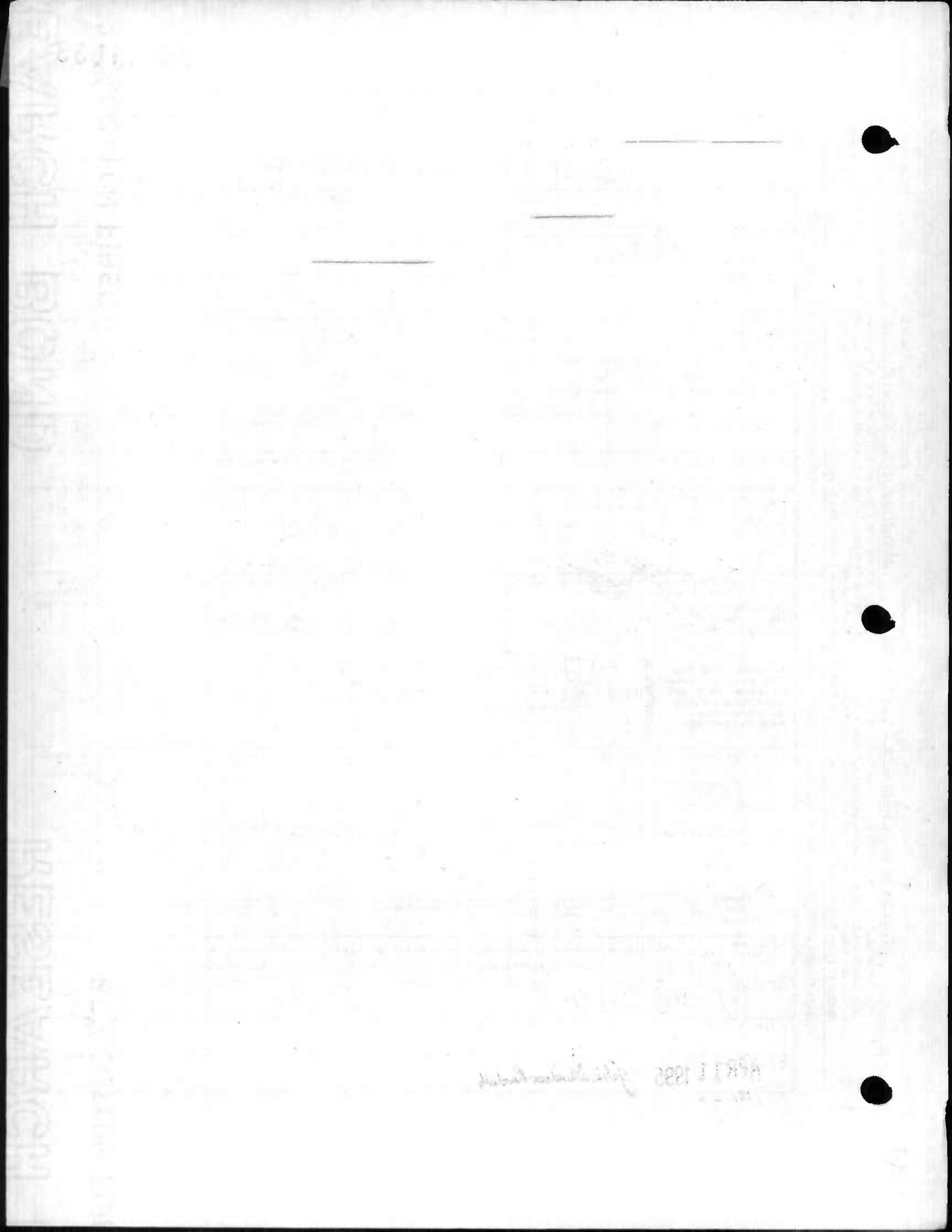
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11034

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lawrence Edward Martin, Sr.</u>				2. DATE OF DEATH MONTH DAY YEAR <u>April 5, 1995</u>		3. TIME OF DEATH <u>15:33 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>214 26 2881</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>66</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Jan. 21, 1929</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Md.</u>				9a. FACILITY NAME (If not Institution, give street and number) <u>Carroll County General Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Westminster</u>	
9c. COUNTY OF DEATH <u>Carroll</u>				10a. STATE <u>Md.</u>		10b. COUNTY <u>Carroll</u>	
10c. CITY, TOWN OR LOCATION <u>Sykesville</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>1266 Buckhorn Road</u>	
10f. ZIP CODE <u>21784</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>-</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Engineer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Engineering</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Philip Martin</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Viola B. Kaulfuss</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Carolyn L. Martin</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1266 Buckhorn Road Sykesville, Md. 21784</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery April 8, 1996 Balto. Md.</u>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Harry W. Haight</u>				22. NAME AND ADDRESS OF FACILITY <u>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus Type II</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D33540</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/6/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>RISA KRAMER MD 6468 Ridge Rd. Sykesville MD 21784</u>							
31. DATE FILED (Month, Day, Year) <u>APR 11 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

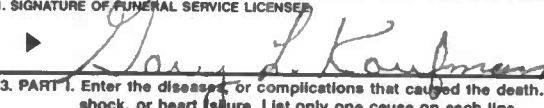
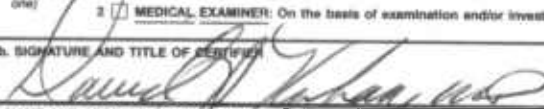
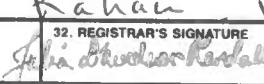
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11035

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CLARENCE EUGENE MEADOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 8 1995</b>		3. TIME OF DEATH <b>0656 AM</b>	
4. SOCIAL SECURITY NUMBER <b>223-01-2240</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 5, 1919</b>	
8. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Wynnewood</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>4712 Ruby Ave.</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Systems Designer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Chessie System</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sylvester Meador</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora E. Rucker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Janie B. Meador</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4712 Ruby Ave., Wynnewood, Md. 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. LOCATION — City or Town, State <b>Elkridge, Md.</b>		20d. DATE <b>4/12</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ventricular Dysrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Myelodysplasia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> BOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>David J. Kahan M.D.</b>				29c. LICENSE NUMBER <b>D35572</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David J. Kahan M.D. Saint Agnes Hospital, Baltimore, Maryland</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10  
1VA



95 11036

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESSIE V. MEARS</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217-12-9692</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 18, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1306 Winston Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1306 WINSTON AVENUE</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>8th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES MEARS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH BIVENS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RHONDA COHEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1306 WINSTON AVENUE/BALTIMORE, MD 21239</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL PARK 4/12</b>		20c. LOCATION — City or Town, State <b>LAUREL, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 1101 E. North Avenue/Baltimore, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Uremia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>End Stage Renal Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <i>2 weeks</i> <i>19 mos</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony N. Adams (Nephrologist)</i>				29c. LICENSE NUMBER <b>D38182</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Anthony N. Adams MD 7402 Tuck Rd Suite 201 Towson MD</i>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>John B. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11037

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph Miller</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>4</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:33 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>n/A</b>		5. SEX <b>XX M</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 31, 1955</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
11. COUNTY OF DEATH <b>N/A</b>				12. RESIDENCE OF DECEDENT		13. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14a. STATE <b>MD</b>		14b. COUNTY <b>N/A</b>		14c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		14d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
15. STREET AND NUMBER <b>2753 TIVOLY AVENUE</b>				16. ZIP CODE <b>21218</b>		17. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>N/A</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		24. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
25. FATHER'S NAME (First, Middle, Last) <b>JAMES EDWARD MILLER</b>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAMIE ALLEN</b>			
27. INFORMANT'S NAME (Type/Print) <b>MAMIE MILLER</b>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2753 TIVOLY AVENUE/BALTIMORE, MD 21218</b>			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CM 4-B</b>		31. LOCATION — City or Town, State <b>LANSDOWNE, MARYLAND</b>			
32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nashu E. Jones</i>				33. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HYPoxic ENCEPHALOPATHY 2° ASPHYXATION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. D.C. APPROVED OCME</b> DUE TO (OR AS A CONSEQUENCE OF): d.							
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>APRIL 4, 1995</b>		28b. TIME OF INJURY <b>unknown</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>ASPHYXATION</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>unknown</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>unknown</b>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lan Mahon, D.O.</i>				29c. LICENSE NUMBER <b>AT2438946A40</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 4, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lan Mahon, D.O.: Union Memorial Hospital, 201 E. A. University Parkway, Baltimore, Md. 21218</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11038

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SIDNEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>7</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>10:20 P</b> M	
4. SOCIAL SECURITY NUMBER <b>218-66-1493</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 17, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4535 MARYKNOLL RD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4535 MARYKNOLL RD.</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>NONE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NONE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>NONE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA</b>		<b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>KATHY NEIDERHEISER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7215 YORK ROAD, TOWSON, MD. 21204</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC CANCER</b>									
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) <b>4-8-95</b>					
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29b. LICENSE NUMBER <b>035085</b>		29c. DATE SIGNED (Month, Day, Year) <b>4-8-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALAN LEVITT MD. 861 PARK AVENUE BALTIMORE MD 21201</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11039

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Leo Nowlin</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>02:15 A</b>	
4. SOCIAL SECURITY NUMBER <b>236-48-5233</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG, 1933</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>IRVINGTON KNOLLS CARE CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>22 SOUTH ATHOL AVENUE</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>SINGLE</b> 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH GRADE</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STOCK PERSON</b>		15b. KIND OF BUSINESS/INDUSTRY <b>GARMENT INDUSTRY</b>					
17. FATHER'S NAME (First, Middle, Last) <b>LONNIE NOWLIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALBERTA CRUMP</b>					
19a. INFORMANT'S NAME (Type/Print) <b>LEON NOWLIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4631 COLEHERNE RD., BALTIMORE, MD. 21229</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST CEMETERY</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>10 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's dementia, Diabetes, chronic renal failure</b>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>2</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>3</b> <input type="checkbox"/> Accident <b>8</b> <input type="checkbox"/> Could not be determined <b>4</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Samih Jarjour MD.</b>				29c. LICENSE NUMBER <b>D02062</b>		29d. DATE SIGNED (Month, Day, Year) <b>April-7-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SAMIH JARJOUR St. Agnes Hospital, 900 Caton AVE BALTIMORE, MD. 21229</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Albert Neal</i> Albert Alphonso Neal		2. DATE OF DEATH MONTH DAY YEAR 04 09 1995		3. TIME OF DEATH 6:13 A M	
4. SOCIAL SECURITY NUMBER 215-18-5899		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.	
7. DATE OF BIRTH (Month, Day, Year) AUG. 30, 1923		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD			
9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1400 E. MADISON STREET apt.207		10f. ZIP CODE 21205	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (SA) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY STATE of MARYLAND MORGAN STATE UNIVERSITY	
17. FATHER'S NAME (First, Middle, Last) ALPHONSO NEAL		18. MOTHER'S NAME (First, Middle, Maiden Surname) AMANDA SMITH			
19a. INFORMANT'S NAME (Type/Print) ROBERT NEAL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 SHERIDAN AVENUE, BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEMETERY		20c. LOCATION — City or Town, State 4-14 OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>		22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death  one week two weeks 5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>prostate cancer</i>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael P. Go (NGO) M.D.</i>		29c. LICENSE NUMBER P06846	
29d. DATE SIGNED (Month, Day, Year) 04/09/95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE <i>John A. Hordell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Patricia ANN Parrish</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 8 1995</i>		3. TIME OF DEATH <i>4:50 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>217-38-1381</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>54</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 13, 1941</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Howard Co. Gen. Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>	
9c. COUNTY OF DEATH <i>Howard Co. Md</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>none</i>	
10c. CITY, TOWN OR LOCATION <i>Balto. City, Md.</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>2928 Baltimore St.</i>	
10f. ZIP CODE <i>21224</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12th. Grade</i> <i>College (1-4 or 5+) none</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mould Inspector</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Carr Lowery Glass Co.</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Charles A. Parrish</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Dolores A. Wachter</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Audrey M. Anderson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2928 E. Baltimore St, Balto. Md. 21224</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holy Cross Cemetery, 8/11/95</i>		20c. LOCATION — City or Town, State <i>A.A. Co. Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Funeral Balto. Md. 21230 Ave. McCully Funeral Home, 130 E. Fort</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Respiratory Failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Heart Failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Ovarian Cancer metastatic</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Anemia, Anorexia - Cachexia.</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jan M. [Signature] MD.</i>				29c. LICENSE NUMBER <i>D30573</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-8-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>11065 Little Patuxent Parkway Columbia MD 21044</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11042

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES JOSEPH PROVENZA</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>06</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-09-2759</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/16/19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FREDERICK</b>		9c. COUNTY OF DEATH <b>FREDERICK</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>FREDERICK</b>		10c. CITY, TOWN OR LOCATION <b>FREDERICK</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>312-#1B Selwyn Drive</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12th Grade</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUBSTATION TECH.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BG&amp;E</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH PROVENZA</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARIE CALVERT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHARLENE STITELY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>&amp;())\$ Hawthorne Dr. Frederick, MD 21702</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>4/10/95 BROOKLYN PK, MD.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina A. Kopyeff</i>				22. NAME AND ADDRESS OF FACILITY <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>15 YRS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARKINSON'S DISEASE / COPD / SMOKING / DEPRESSION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew O. Donelson</i>				29c. LICENSE NUMBER <b>D 21936</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-7-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW O. DONELSON 915 TOLLHOUSE # 203 FREDERICK 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Caroline Peppler				2. DATE OF DEATH MONTH DAY YEAR April 9, 1995		3. TIME OF DEATH 11:50 P.M.	
4. SOCIAL SECURITY NUMBER 216-48-0486		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 11, 1894	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center - Loch Raven		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore County				10a. STATE Maryland		10b. COUNTY Baltimore County	
10c. CITY, TOWN OR LOCATION County - Parkville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8720 Emge Road	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) John Unknown Weber				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Unknown Medal			
19a. INFORMANT'S NAME (Type/Print) John F. Peppler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2467 Woodcroft Road, Baltimore, Maryland-21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 4/12/95		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. Baltimore, Maryland 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UREMIA DUE TO (OR AS A CONSEQUENCE OF): b. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DEHYDRATION DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 1 MONTH > 6 MONTHS > 6 MONTHS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMEMENTIA, DIABETIS MELLITUS							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Felix Tan M.D.				29c. LICENSE NUMBER D14959		29d. DATE SIGNED (Month, Day, Year) April 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FELIX TAN M.D. 4000 BRIDMAN AVE. BALTIMORE, MD 21213							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE Julia M. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11044

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VERNON T PITTINGER</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>4</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:40 pm</b> M	
4. SOCIAL SECURITY NUMBER <b>215-07-6167</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 21, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>				11. COUNTY OF DEATH <b>Baltimore</b>			
12a. STATE <b>Maryland</b>		12b. COUNTY <b>Baltimore</b>		12c. CITY, TOWN OR LOCATION <b>Towson</b>		12d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
13a. STREET AND NUMBER <b>800 Southerly Rd.</b>				13b. ZIP CODE <b>21286</b>		13c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs</b>		19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice President</b>		20. KIND OF BUSINESS/INDUSTRY <b>Banking</b>			
21. FATHER'S NAME (First, Middle, Last) <b>Charles Pittinger</b>				22. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Albrecht</b>			
23. INFORMANT'S NAME (Type/Print) <b>Anne B. Buckler</b>				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>507 Chestnut Ct. LaPlata, Md. 20646-9576</b>			
25. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		26. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Weller United Methodist 4-10</b>		27. DATE <b>4-10</b>		28. LOCATION — City or Town, State <b>Thurmont, Md.</b>	
29. SIGNATURE OF FUNERAL SERVICE LICENSEE 				30. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>BILATERAL PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>DEMENTIA</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY <b>M</b>		38. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				40. DESCRIBE HOW INJURY OCCURED			
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
42. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
43. SIGNATURE AND TITLE OF CERTIFIER <b>Joginder P Mehta M.D.</b>				44. LICENSE NUMBER <b>D41410</b>		45. DATE SIGNED (Month, Day, Year) <b>04-04-95</b>	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOGINDER P MEHTA MD, ST. JOSEPH MEDICAL CENTER, TOWSON, MARYLAND 21204</b>							
47. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		48. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

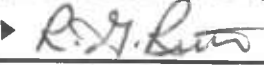



95 11045

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>STEPHEN M. PLEMENS</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>07</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:00 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-48-1273</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-29-47</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>217 WEST LANVALE STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>217 WEST LANVALE STREET</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 PLUS</b> College (1-4 or 5+) <b>5 PLUS</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BARBER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. NAVAL ACADEMY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MARTIN PLEMENS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CATHERINE M. HELLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FREDERICK S. KOONTZ</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 SAINT PAUL STREET, BALTIMORE, MD., 21202</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY 4-8</b>			
20c. LOCATION — City or Town, State <b>BALTO., MD. 21202</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS 4905 YORK ROAD, BALTIMORE, MD. 21212</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>HIV</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumocystis, staphylococcus</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>outpatient hospice</b>			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>04-07-95</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER <b>D 13012</b>				29d. DATE SIGNED (Month, Day, Year) <b>04-07-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN W. PAYNE M.D., 6565 NORTH CHARLES STREET, TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11046

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES ROSCOE QUEEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>		3. TIME OF DEATH <b>13:46 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-1301</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAR. 18, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1562 Montpelier Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1562 Montpelier Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE CITY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>n/a</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EFFIE SOMMERVILLE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANITA TURNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1836 CHESTER STREET/BALTIMORE, MD 21213</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM4/13</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>		22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 21202 1101 E. NORTH AVE./BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 21202 1101 E. NORTH AVE./BALTIMORE, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ruptured Thoracic Aneurysm</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Thoracic Aneurysm</b> <b>Atherosclerosis, HTN</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>022788</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Spencer B. Bell MD 3333 N. Calvert St. Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

6  
10A

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11047

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN STEWART RAY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>05</b> YEAR <b>95</b>		3. TIME OF DEATH <b>00:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>232-18-3510</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 30, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Howard County</b>				10c. CITY, TOWN OR LOCATION <b>Cooksville</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>14379 Old Frederick Road</b>			
10f. ZIP CODE <b>21723</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State of Maryland</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Blondie Ray</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bethel Jarvis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. French O. Ray</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14359 Old Frederick Road, Cooksville, MD 21723</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sharon Missionary Baptist Church Cem. 4-8-95</b>		20c. LOCATION — City or Town, State <b>Cooksville, MD</b>		20d. DATE <b>4-8-95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure with severe Hypotension</b> Approximate Interval Between Onset and Death <b>18 days</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Myocardial Infarction</b> Approximate Interval Between Onset and Death <b>1 month</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Myelomonocytic leukemia (3 months)</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Resident</b>				29c. LICENSE NUMBER <b>D-44789</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/05/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KATHY MARINO, U. Dept. of Medicine, St. Agnes Hospital, 900 CATON AVE, BALTIMORE, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11048

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HANA ROISMAN</b>				2. DATE OF DEATH MONTH <b>9</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-11-0201</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 10, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>RUMANIA</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		10. COUNTY OF DEATH <b>MONTGOMERY</b>	
11. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				12. RESIDENCE OF DECEDENT <b>BALTIMORE</b>		13. STATE <b>MARYLAND</b>	
14. STREET AND NUMBER <b>6908 MARSUE DRIVE, APT. #1-A</b>				15. ZIP CODE <b>21215</b>		16. CITIZEN OF WHAT COUNTRY? <b>RUMANIA</b>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12th.</b> College (1-4 or 5+) <b>HOUSEWIFE</b>		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT HOME</b>		23. KIND OF BUSINESS/INDUSTRY			
24. FATHER'S NAME (First, Middle, Last) <b>SMIL HERMAN</b>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LITZA SOLOMOVICI</b>			
26. INFORMANT'S NAME (Type/Print) <b>MR. WILLIAM ROISMAN</b>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11409 CLOVERHILL DRIVE, SILVER SPRING, MD. 20902</b>			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHAAREI TFILOH CONGRGATION 4/9/95 BALTIMORE, MD.</b>		30. DATE		31. LOCATION — City or Town, State	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				33. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215</b>			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → <b>Metastatic Pancreatic Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>9mo</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
39. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		40. DATE OF INJURY (Month, Day, Year)		41. TIME OF INJURY <b>M</b>		42. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				44. DESCRIBE HOW INJURY OCCURRED			
45. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
46. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
47. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>FREDERICK G. BARR MD.</b>				48. LICENSE NUMBER <b>022775</b>		49. DATE SIGNED (Month, Day, Year) <b>4-9-95</b>	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FREDERICK G. BARR MD 5454 WISCONSIN AVE, Chevy Chase, MD</b>							
51. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		52. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11049

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis Leon Rytlewski Sr.				2. DATE OF DEATH MONTH DAY YEAR 4 6 95		3. TIME OF DEATH 4:20 P M	
4. SOCIAL SECURITY NUMBER 527-28-7731		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 12, 1930	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) 3321 Leritz Lane		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Edgewater	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3321 Leritz Lane				10f. ZIP CODE 21037		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Patent Examiner		16b. KIND OF BUSINESS/INDUSTRY US Patent & Trademark			
17. FATHER'S NAME (First, Middle, Last) John Francis Rytlewski SR				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ostrowski			
19a. INFORMANT'S NAME (Type/Print) Margaret Anne Rytlewski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3321 Leritz Lane, Edgewater, MD 21037			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 4/6		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Batrick J. Amell</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Paul Cell Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John P. Watkins</i>				29c. LICENSE NUMBER D08118		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.P. WATKINS 900 BRISTOL RD ANN MD 21401							
31. DATE FILED (Month, Day, Year) APR 11 1995		REGISTRAR'S SIGNATURE <i>John A. Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11050

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD L. ROACH				2. DATE OF DEATH MONTH DAY YEAR APRIL 07, 1995		3. TIME OF DEATH 2:15 P.M.	
4. SOCIAL SECURITY NUMBER 216-28-3421		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 21, 1927	
9a. FACILITY NAME (If not Institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTO, CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 2017 BELAIR RD.				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES NOV. 29/52-FEB. 14-56		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENGINEER		16b. KIND OF BUSINESS/INDUSTRY BALTO, CITY SCHOOL SYS.	
17. FATHER'S NAME (First, Middle, Last) AGUSTA ROACH JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE HUGH			
19a. INFORMANT'S NAME (Type/Print) LINDA ROACH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 MAY CT. BALTO, MD. 21231			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA.CEM. APR. 13, '95		20c. LOCATION — City or Town, State OWINGSMILLS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):							
b. ANOXIC BRAIN INJURY DUE TO (OR AS A CONSEQUENCE OF):							
c. VENTRICULAR FIBRILLATION ARREST DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Varghese M.D.</i>				29c. LICENSE NUMBER M6180		29d. DATE SIGNED (Month, Day, Year) APRIL 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL VARGHESE TOWER 110 JOHNS HOPKINS HOSPITAL							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>John A. Buckner-Karrell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020



95 11051

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles FRANKLIN Randall</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 1, 1995</b>		3. TIME OF DEATH <b>6:24 AM</b>	
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>May 9, 1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>920 Carrollton Avenue</b>			
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Randall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Dorsey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Vernon L. Randall, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1704 E. 29th Street/Baltimore, Maryland 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. GREGORY'S CHURCH CEM. 4/8</b>		20c. LOCATION — City or Town, State <b>COOKSVILLE, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Washburne E. Prince</i>	
22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST</b>		22. NAME AND ADDRESS OF FACILITY <b>1101 E. NORTH AVENUE/BALTIMORE, MARYLAND</b>		22. NAME AND ADDRESS OF FACILITY <b>21202</b>		22. NAME AND ADDRESS OF FACILITY <b>21202</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. Arrhythmia c. Cardiomyopathy d.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Aileen S. Garcia - Gayoso</i>		29c. LICENSE NUMBER <b>89223</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-1-95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Aileen Garcia-Gayoso M.D. C/O Maryland General Hospital</b>	
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>		32. REGISTRAR'S SIGNATURE		32. REGISTRAR'S SIGNATURE	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11052

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM PERRY RORIE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 4, 1995</b>		3. TIME OF DEATH <b>14:00 p<sup>m</sup></b>	
4. SOCIAL SECURITY NUMBER <b>248-50-5263</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 22, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S. Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1531 Lester Morton Court Apt. 5</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (14 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WHITAMORE RORIE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MELAND EVANS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>TYSIE JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4802 GREENCREST ROAD/BALTIMORE, MD 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Yoshell Mem Garden 4/8/95 Dundalk, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>30 min</b>	
		b. <b>Hypoxia</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>45 min</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>Metastatic Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>4 years</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James R. Miller, MD</b>				29c. LICENSE NUMBER <b>JRN # C9743</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James E. Miller, 601 W. Carolina St., Baltimore MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11053

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WALTER EDWARD RHEW, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1995</b>		3. TIME OF DEATH <b>11:55 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>242-07-0238</b>		5. SEX <b>1 M 2 F</b>	6. AGE (In yrs. last birthday) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>May 10, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>104 Centre Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>104 Centre Ave.</b>	
10f. ZIP CODE <b>21286</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>WW-II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Owner</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plesant Plains Amoco</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Ed Rhew</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Hicks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Lola Aiken</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Centre Ave. Towson, Md. 21286</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gdns. 4/10/95</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ADENOCARCINOMA, PROSTATE W/ METS</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>023967</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Cesar G. Gamboa, M.D. 3440 Belair Rd. Baltimore, Md. 21213</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10410K





95 11054

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) May T. Runge				2. DATE OF DEATH MONTH DAY YEAR April 7, 1995		3. TIME OF DEATH 5:45 P. M	
4. SOCIAL SECURITY NUMBER 216-36-1084		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-27-1908	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH Cockeysville		10. COUNTY OF DEATH Baltimore	
11. FACILITY NAME (If not institution, give street and number) Maryland Masonic Home							
12. RESIDENCE OF DECEDENT							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY, TOWN OR LOCATION Towson		13d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
14a. STREET AND NUMBER 521 Valley View Road				14b. ZIP CODE 21286		14c. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		18. RACE — American Indian, Black, White, etc. Specify: White	
19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		21. KIND OF BUSINESS/INDUSTRY Own Home			
22. FATHER'S NAME (First, Middle, Last) Henry W. Berger				23. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Ashauer			
24. INFORMANT'S NAME (Type/Print) Henry W. Runge				25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10			
26. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 4-10-95		28. LOCATION — City or Town, State Parkville, Maryland			
29. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr.				30. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>long history of Diabetes</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>long history of Arteriosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>long history of Arteriosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
33. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				34. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		37. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
38. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY M		41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		43. DESCRIBE HOW INJURY OCCURRED					
44. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
39a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
39b. SIGNATURE AND TITLE OF CERTIFIER Benjamin K. Yorkoff, M.D.				39c. LICENSE NUMBER 120507		39d. DATE SIGNED (Month, Day, Year) 4/10/95	
39e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin K. Yorkoff, M.D. 7401 Osler Drive, Towson, Md. 21204							
39f. DATE FILED (Month, Day, Year) APR 11 1995		39g. REGISTRAR'S SIGNATURE John H. Harkins					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11055

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gustav Edward Rauf</i>		2. DATE OF DEATH MONTH <i>April</i> , DAY <i>6</i> , YEAR <i>1995</i>		3. TIME OF DEATH <i>1:51 P</i> M	
4. SOCIAL SECURITY NUMBER <i>212-34-5090</i>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>80</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>June 7, 1914</i>	8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Ctr.</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT					
10a. STATE <i>Maryland</i>	10b. COUNTY <i>Baltimore</i>	10c. CITY, TOWN OR LOCATION <i>Dundalk</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1844 East Avenue</i>		10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (8-12)</i> <i>8 Years</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Pipe Mill Foreman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Steel Industry</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Ludwig Rauf</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Minnie Krausz</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Carol J. Rossi</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1844 East Avenue Dundalk, Maryland 21222</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery 4/10/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i>					
DUE TO (OR AS A CONSEQUENCE OF):					
<i>Coronary Artery Disease</i>					
DUE TO (OR AS A CONSEQUENCE OF):					
<i>Atrial Fibrillation</i>					
DUE TO (OR AS A CONSEQUENCE OF):					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>04/06/95</i>		28b. TIME OF INJURY <i>1:40 PM</i>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home -&gt; garden.</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mei-Hui Wang</i>		29c. LICENSE NUMBER <i>245972</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/7/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mei-Hui Wang 2112 Dundalk Ave. Baltimore, MD 21222</i>					
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Martha H. Reese				2. DATE OF DEATH MONTH 3 DAY 30 YEAR 95				3. TIME OF DEATH 10:15 A M					
4. SOCIAL SECURITY NUMBER 212-34-8050		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 01/28/18		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Solomons Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Solomons				9c. COUNTY OF DEATH Calvert			
10a. STATE Maryland				10b. COUNTY Calvert				10c. CITY, TOWN OR LOCATION Solomons				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13325 Dowell Rd.						10f. ZIP CODE 20688-1509				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife Mail Sorter				15b. KIND OF BUSINESS/INDUSTRY Advertising					
17. FATHER'S NAME (First, Middle, Last) Hubert Hefner						18. MOTHER'S NAME (First, Middle, Maiden Surname) Belle Bennett							
19a. INFORMANT'S NAME (Type/Print) Tim Sayre						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12625 Catalina Dr. P.O. Box 100 Lusby, MD 20657							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodsdale Memorial Park DATE 4-3				20c. LOCATION — City or Town, State Grafton, West Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome Znamenski</i>						22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225							
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 year													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Previous Cerebro vascular accident													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Charles Bennett M.D.						29c. LICENSE NUMBER D25156			29d. DATE SIGNED (Month, Day, Year) March 30, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Bennett M.D. 11845 H.G. Tureman Road Solomons, Maryland 20688													
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11057

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARLOS GIOVANNI RUIZ</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8: 45</b> P M	
4. SOCIAL SECURITY NUMBER <b>112-48-1934</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-26-57</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>719 Washington Pl. 3rd Floor</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO	
10e. STREET AND NUMBER <b>719 Washington Pl. 3rd Floor</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify: <b>Puerto Rican</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>N/A</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> yr. College (1-4 or 5+) <b>4</b> yr.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Actor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elvin Ruiz</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Juanita Correa</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Winder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>905 Central Ave. Baltimore, Md. 21202</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Municipal Cemetery</b>		DATE <b>4/14</b>		20c. LOCATION — City or Town, State <b>Cabo Rojo, Puerto Rico</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home East</b> <b>1101 E. North Avenue/Baltimore, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. AIDS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO <b>X</b>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO <b>X</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO <b>X</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>3</b> Suicide <b>6</b> Could not be determined <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER (Desmanjiles)				29c. LICENSE NUMBER <b>D44400</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>821 N. Ertow St #405</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11058

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSE MARIE ROBERTS</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>5</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213 36 4711</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1937</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not Institution, give street and number) <b>287 Stanley Terrace</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>287 Stanley Terrace</b>		10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Office Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Doctors Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Roberts</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Zang</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dr. Robert Mathieson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3333 N. Calvert Street Suite 680 Balto., Md. 21218</b>			
20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		DATE <b>4/7</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard Home</b>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonca Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>METASTATIC BRAIN CANCER</b> c. <b></b> d. <b></b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert D. Mathieson M.D.</b>				29c. LICENSE NUMBER <b>21327</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT D. MATHIESON M.D. 3333 N. CALVERT ST STE 680 BALTO MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>							

ONMN-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rosabelle B. Sopher</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 6 1995</b>		3. TIME OF DEATH <b>09:10 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-26-6364</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 4, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2714 WOODCOURT ROAD</b>	
10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GROCCER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOOD</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS BERLIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JENNIE WOLMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. RUTH SUROSKY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2714 WOODCOURT ROAD BALTIMORE, MD 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>(ANSHE EMUNAH) AITZ CHAIM 4-9-1995 BALTIMORE, MD</b>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Glenore Swinson</b>			
22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Aortic Stenosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 year</b> <b>1 year</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John A. Lippert, MD Resident Physician</b>				29c. LICENSE NUMBER <b>AS2403321-JL9836</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 6, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John A. Lippert, MD Sinai Hospital of Baltimore</b>				31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>			
32. REGISTRAR'S SIGNATURE <b>John A. Lippert</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

12



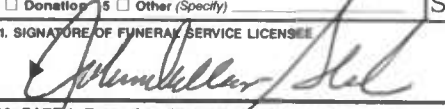

NOT RECORDED BY 2001-11-15



95 11060

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ralmond L. Sealing</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 06 1995</b>		3. TIME OF DEATH <b>12:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-4609</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 17, 1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Church Home and Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>100 Northeast Avenue</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Commercial</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Howard Sealing</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Moore</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ms. Susan Shaffer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9679 Baltimore Avenue, Laurel, Maryland 20723</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. John's Lutheran Cem. 4-8-95</b>		20c. LOCATION — City or Town, State <b>Pfeiffers Crnr., MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE MYELOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PROSTATE CANCER</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A.P. NAZEMI</b>				29c. LICENSE NUMBER <b>D17322</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 06, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.P. NAZEMI, M.D. CHURCH HOSPITAL, BALTIMORE MD 21231</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11061

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEATRICE K. STERN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>5</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-24-1666</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 21, 1899</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7313 PARK HEIGHTS AVE. APT. 201</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7313 PARK HEIGHTS AVE. APT. 201</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		15b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HENRY KRAUS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HENRIETTA HAMBURGER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. JILL R. MYERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2944 WOODVALLEY DRIVE BALTIMORE, MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW 4-7-1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		20d. DATE <b>4-7-1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD. BALTO., MD (21215)</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>anemia, lupus, chronic obstructive lung disease</b>							Approximate Interval Between Onset and Death <b>1 day</b>  <b>5 years</b>
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>home</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D20604</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>#306, 4000 Old Court Rd, Pikesville, Md 21208</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11062

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH SHERMAN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>6</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:43am</b> M	
4. SOCIAL SECURITY NUMBER <b>216-09-0613</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAR. 5, 1905</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6401 DORAL DRIVE APT. B</b>			
10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CHAUFFEUR</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHAUFFEUR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TRANSPORTATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ABRAHAM SHERMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LEAH PACH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. ELIZABETH SHERMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6401 DORAL DRIVE APT. B BALTIMORE, MD 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or institution, etc.) <b>ANSHE EMUNAH (AITZ CHAIM) 4/7/95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		20d. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D Lewis</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>4 yrs</b> <b>10 yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew D. Glick</i>				29c. LICENSE NUMBER <b>033977</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Andrew D. Glick 6804 Park Heights Ave Baltimore Md 21205</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mildred Anna Smith</i>				2. DATE OF DEATH MONTH <i>04</i> DAY <i>06</i> YEAR <i>1995</i> TIME OF DEATH <i>1 PM</i>							
4. SOCIAL SECURITY NUMBER <i>119 05 5557</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH MONTH <i>04</i> DAY <i>11</i> YEAR <i>1913</i>		8. BIRTHPLACE (State or Foreign Country) <i>NEW YORK</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Asbury Home, Russell Ave</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Gaithersburg</i>				9c. COUNTY OF DEATH <i>Montgomery</i>			
10a. STATE <i>MD</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>211 Russell St.</i>				10f. ZIP CODE <i>20877</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Peter Magnuson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Strandberg</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Brian W. Smith</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5504 Prince William Court, Frederick, MD 21701</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley Mem. Gardens</i>		DATE <i>APR 10</i>		20c. LOCATION — City or Town, State <i>Timonium, MD 21093</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lowell M. Lemmon</i>				22. NAME AND ADDRESS OF FACILITY <i>Lemmon Funeral Home</i> <i>10 W. Padonia Rd., Timonium, MD 21093</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>d.</i>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Assisted living</i>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jovanna Moreno MD</i>						29c. LICENSE NUMBER <i>041463</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/6/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jovanna Moreno 400 S. Washington St Alexandria VA</i>											
31. DATE FILED (Month, Day, Year) <i>4/11/95</i>				32. REGISTRAR'S SIGNATURE <i>John J. Randolph</i>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11064

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Shorter Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>		3. TIME OF DEATH <b>7:30a</b> M	
4. SOCIAL SECURITY NUMBER <b>218-44-0284</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>49</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 30, 1946</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1405 Generals Highway</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Crownsville</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crownsville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1405 Generals Highway</b>				10f. ZIP CODE <b>21032</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Air Condition/Refrigeration</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin R. Shorter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Mae Evans</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Benjamin R. Shorter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1405 Generals Highway, Crownsville, MD</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery 4/12</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Metastatic Adenocarcinoma</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Carcinoma Colon</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Constantine Padussis</i>				29c. LICENSE NUMBER <b>D18823</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>736 Ritchie Hwy Suite 500 Constantine Padussis</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11065

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH SCHRAMKEK</b> AKA <b>RUTH SARAH SCHRAMKEK</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>4</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:20 a m</b>	
4. SOCIAL SECURITY NUMBER <b>212-18-4841</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 19, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>NA</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Anne Arundel</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore (Brooklyn Park)</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>3 Bon Air Road,</b>			
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker and Mother</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MEHRL PHEBUS, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BERTHA SCHEMINANT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. David Schramek</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5724 Pope St., Baltimore, Md. 21225</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Cedar Hill Cemetery 4/7/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		20d. DATE <b>4/7/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>CHRONIC RENAL FAILURE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Raghuveer Shenoj MD</b>				29c. LICENSE NUMBER <b>AS244161436</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 6th 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR RAGHUVVEER SHENOJ M.D HARBOR HOSPITAL - BALTIMORE.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11066

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDDIE MARIE SWANSON</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-30-9674</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 18, 1934</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>4462 FLINTVILLE RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>WHITEFORD</b>	
9c. COUNTY OF DEATH <b>HARFORD</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HARFORD</b>	
10c. CITY, TOWN OR LOCATION <b>WHITEFORD</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4048A PROSPECT RD.</b>	
10f. ZIP CODE <b>21160</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELECTRICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WESTINGHOUSE COMMUNICATIONS CORP.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CLARENCE SPONAUGLE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VISTA BELLE BODKIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PAMELA M. SHORT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4048A PROSPECT RD.; WHITEFORD MD 21160</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY 4/10/95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen D. Lohrmann</i>				22. NAME AND ADDRESS OF FACILITY <b>CAFA STEPHEN D. LOHRMANN P.A. 21286 8717 GREEN PASTURES DR.; BALTIMORE MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Remitt B Lochman</i>		29c. LICENSE NUMBER <b>045421</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1916 Belair Rd Fallston Md 21047</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>Julia Swanson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020


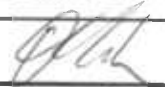

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VIOLET JOAN SHERPINSKI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 4, 1995</b>		3. TIME OF DEATH <b>3:40 P M</b>			
4. SOCIAL SECURITY NUMBER <b>219-28-1594</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-08-1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>Poland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2211 DUKER COURT</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>NA</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>NA</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7232 Gough Street</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>L.P.N.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Rosewood St. Hospital</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles Sherpinski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pheobe Pointkowski</b>					
19a. INFORMANT'S NAME (Type/Print) <b>John Sherpinski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7232 Gough St., Baltimore, Md. 21224</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		DATE <b>4/6</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lilly &amp; Zeiler Inc. 1901 Eastern Avenue 21231</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 5, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID R. FOWLER M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 16b, PER F.H. FILM G-722 4/11/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ABIGAIL N. SPRIGGS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 07 1995</b>		3. TIME OF DEATH <b>3:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-56-6975</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/8/29</b>	
8. FACILITY NAME (If not institution, give street and number) <b>3920 BLACKBURN LANE #41</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BURTONSVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>BURTONSVILLE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3920 BLACKBURN LANE #41</b>				10f. ZIP CODE <b>20866</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NURSE I.P.N.</b>		16b. KIND OF BUSINESS/INDUSTRY <del>SELFEMPLOYED</del> <b>SELF EMPLOYED</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT BUTLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NANNIE WADE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CAMERON SPRIGGS (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3935 DUNESWAY, BURTONSVILLE, MD 20866</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY 4/11</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>THERMAL INJURY</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4/7/95</b>		28b. TIME OF INJURY <b>2:42 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>victim of house fire</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3920 Blackburn Burtonsville, MD.</b>							
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 07, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1945-027  
B.K.S.

95 11069

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACQUELYN MARIE SEELY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>06</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1830 P M</b>	
4. SOCIAL SECURITY NUMBER <b>365-56-3128</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCTOBER 7, 1950</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MICHIGAN</b>				9. COUNTY OF DEATH <b>HOWARD</b>			
10. FACILITY NAME (If not institution, give street and number) <b>10516 EAST WIND WAY</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>COLUMBIA</b>		12. COUNTY OF DEATH <b>HOWARD</b>	
13. STATE <b>MARYLAND</b>		14. COUNTY <b>HOWARD</b>		15. CITY, TOWN OR LOCATION <b>COLUMBIA</b>		16. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
17. STREET AND NUMBER <b>10516 EAST WIND WAY</b>				18. ZIP CODE <b>21045</b>		19. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
20. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ACCOUNTANT</b> <b>CERTIFIED PUBLIC</b>		26. KIND OF BUSINESS/INDUSTRY <b>ACCOUNTING</b>			
27. FATHER'S NAME (First, Middle, Last) <b>LEONARD EDWARD PARKS</b>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES IRENE HEWITT</b>			
29. INFORMANT'S NAME (Type/Print) <b>FRANCES IRENE GREGORY</b>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8313 HARRIET LANE SEVERN, MARYLAND 21144</b>			
31. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORPORATION</b> <b>APRIL 10, 1995</b>		33. LOCATION — City or Town, State <b>TOWSON, MARYLAND</b>			
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Zappala</i>				35. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME PA</b> <b>1 SECOND AVENUE S.W. GLEN BURNIE, MD 21061</b>			
36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CONTACT GUNSHOT WOUND OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
38. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
40. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		41. DATE OF INJURY (Month, Day, Year) <b>4-6-95</b>		42. TIME OF INJURY <b>1630 P M</b>		43. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>RESIDENCE</b>		45. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT SELF</b>					
46. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>10516 EAST WIND WAY HOWARD COUNTY</b>							
47. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER <i>Michael C. Zappala</i>				49. LICENSE NUMBER <b>O.C.M.E</b>		50. DATE SIGNED (Month, Day, Year) <b>APRIL 7, 1995</b>	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marydon P. Kerson</b> <b>111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
52. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		53. REGISTRAR'S SIGNATURE <i>John</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11070

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gertrude A. Schneider</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 9, 1995</b>		3. TIME OF DEATH <b>3 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-07-1498</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 16, 1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3939 Roland Avenue Apt 214</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b> College (1-4 yr 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Lockner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Appleby</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elaine Foreman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10527 Gateridge Rd, Hunt Valley, Md 21030</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Cem</b>		DATE <b>4/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave., Baltimore, Maryland 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ABDOMINAL AORTIC Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>+2y4w</b>
PART II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <b>Heart insufficiency</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward P. Lorth MD</i>				29c. LICENSE NUMBER <b>D19503</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10 GERARD AVE 214 TIMONIUM MD 21093</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHERISE SIMPKINS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:30 A</b> M	
4. SOCIAL SECURITY NUMBER <b>216-90-2012</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>25</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-26-69</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1212 BLOOMINGDALE ROAD</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HEALTH CARE PROVIDER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNK</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard C. Jones JR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KAREN POLLARD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FRANK SIMPKINS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8343 CHURCH LN. APT. 104 BALTO. MD. 21244</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 04-12-95</b>		20c. LOCATION — City or Town, State <b>LANSDOWNE MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ALBERT P. WYLIE F/H PA. 638 N. GILMORE STREET 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BACTERIAL MENINGITIS</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>STREPTOCOCCAL PNEUMONIA SEPSIS</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STREPTOCOCCAL PNEUMONIA SEPSIS</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas S. Miller M.D. PHYSICIAN</b>				29c. LICENSE NUMBER <b>D30272</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS S. MILLER BON SECOURS HOSPITAL - BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

237 14 897

95 11072

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Henry Schauman, Jr.</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>8</i> YEAR <i>95</i>		3. TIME OF DEATH <i>11:30 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>213-36-9448</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>55</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 8, 1940</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard County</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Howard County</i>		10c. CITY, TOWN OR LOCATION <i>Columbia</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6302 Tamar Drive</i>				10f. ZIP CODE <i>21045</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Korean/Vietnam</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12th Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Engineer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Defense Contractor</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Henry Schauman, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret Unknown Einolf</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Linda Ann Geis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1312-T1 Liriope Court, Belcamp, Maryland 21017</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery</i>		DATE <i>4/11/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i>				22. NAME AND ADDRESS OF FACILITY <i>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Lung cancer Adenocarcinoma metastatic stage IV</i> DUE TO (OR AS A CONSEQUENCE OF):  <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF):  <i>d.</i>							Approximate Interval Between Onset and Death <i>2 wks</i>  <i>8 months</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic anemia</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jon H. Mumford</i>				29c. LICENSE NUMBER <i>030573</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-9-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>11065 Little Patuxent Parkway, Columbia MD 21046</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15  
1VA



95 11073

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIA GRACE SPARAGANA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 10 1995</b>		3. TIME OF DEATH <b>4:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>073-03-7189</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 9, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Italy</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Carroll County</b>				10c. CITY, TOWN OR LOCATION <b>Sykesville</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>121 Martz Road</b>			
10f. ZIP CODE <b>21784</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Clothing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Paul Folcarelli</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Gabriel P. Sparagana (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>121 Martz Road Sykesville, MD 21784</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Sepulchar Cemetery 4/12/95 Rochester, New York</b>		20c. LOCATION — City or Town, State		20d. DATE <b>4/12/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian L. Haight</i>				22. NAME AND ADDRESS OF FACILITY <b>HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF ESOPHAGUS</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>1 yr.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R. Faulkner</i>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b> 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>JOANNE VANESSA WILKES</del> JOANNE VANESSA SMITH-WILKES				2. DATE OF DEATH MONTH DAY YEAR April 8 1995		3. TIME OF DEATH 4:25 A.M.	
4. SOCIAL SECURITY NUMBER 218-62-2936		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 6, 1954	
8a. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE				8b. CITY, TOWN OR LOCATION OF DEATH TOWSON		8c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1025 N. BROADWAY				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 2 YEARS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HUD		16b. KIND OF BUSINESS/INDUSTRY HOUSING URBAN DEVELOPMENT	
17. FATHER'S NAME (First, Middle, Last) ARNOLD SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVELYN BROWN			
19a. INFORMANT'S NAME (Type/Print) EVELYN SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 N. BROADWAY, BALTIMORE, MD 21205			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 4/13-4-14		20c. LOCATION — City or Town, State RANDALLSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. C. March</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic cancer, primary unknown DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204							
31. DATE FILLED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>Juli Wheeler</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11075

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Kenneth Grant Steers</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>24</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>2:39 P M</i>	
4. SOCIAL SECURITY NUMBER <i>202-09-8328</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 5, 1920</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Ctr.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>1634 Manor Road</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10 Years</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Carpenter</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Carpenter's Union</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Thomas Steers</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ethel Palm</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Margaret A. Steers</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1634 Manor Road Dundalk, Maryland 21222</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Meadowridge Mem. Cem. 3/28/95</i>		20c. LOCATION — City or Town, State <i>Elkridge, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death <i>3 yrs</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>10 yrs</i>	
		c. <i>Diabetes Type II</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>5 yrs</i>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R.S. Magni M.D.</i>				29c. LICENSE NUMBER <i>D09350</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/27/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R.S. Magni, M.D.</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11076

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MYRTLE TENNYSON SCHOBEL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 8 1995</b>		3. TIME OF DEATH <b>6:30 p<sup>m</sup></b>	
4. SOCIAL SECURITY NUMBER <b>212-74-9662</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB 01, 1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Cockeysville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5 Sandspring Court</b>	
10f. ZIP CODE <b>21030</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Edwards</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Tennyson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret T. Wanke</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Sandspring Court Cockeysville, MD 21030</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/10/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b> <i>Dawn F. McDonald</i>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>G.I. Bleed</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>24<sup>h</sup></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pm 6 Lin md</i>				29c. LICENSE NUMBER <b>D25488</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-9-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Rivas, M.D. - 3421 Sweet Air Road, Phoenix, MD 21131</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11077

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Winston TAYLOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 08, 1995</b>				3. TIME OF DEATH <b>9:00 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-28-5335</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/13/32</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4621 Harcourt Road</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel Corp.</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Linzy C. Taylor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucille Harris</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Lisa Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4621 Harcourt Road Baltimore, Md. 21214</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 4/13</b>		DATE <b>4/13</b>		20c. LOCATION — City or Town, State <b>Arbutus, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Heroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>HEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Adenocarcinoma of lung</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Asbestosis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> d. <b>6 years</b> <b>6 years</b>								Approximate Interval Between Onset and Death <b>2 years</b> <b>6 years</b> <b>6 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Orn Eliasson, M.D.</i>		29c. LICENSE NUMBER <b>D31076</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Orn Eliasson, M.D. 9105 Franklin Sq. Dr. Baltimore MD 21237</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Anderson-Russell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11078

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rita M. Tracy				2. DATE OF DEATH MONTH DAY YEAR April 8, 1995		3. TIME OF DEATH 10:30 P M	
4. SOCIAL SECURITY NUMBER 212-28-1528		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 7, 1929	
9a. FACILITY NAME (If not institution, give street and number) 8131 Oakwood Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8131 Oakwood Rd.				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Bus Contractor		16b. KIND OF BUSINESS/INDUSTRY Transportation			
17. FATHER'S NAME (First, Middle, Last) Joseph Sliveckey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kline			
19a. INFORMANT'S NAME (Type/Print) Dolores Chalfont				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8329 Elvaton Rd., Millersville, Maryland 21108			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Mem. Pk. April 12, 1995		20c. LOCATION — City or Town, State Glen Burnie, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E., Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Cancer of lung					
Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. DUE TO (OR AS A CONSEQUENCE OF):					
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DE2110		29d. DATE SIGNED (Month, Day, Year) April 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suite 300 Marc A. Kaplan, M.D., 7845 Oakwood Rd., Glen Burnie, Maryland 21061							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ADA TRAUTMAN Ader Troutman</u>				2. DATE OF DEATH MONTH DAY YEAR <u>April 10 1995</u>		3. TIME OF DEATH <u>5:45 P M</u>	
4. SOCIAL SECURITY NUMBER <u>218-58-9528</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>86</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>4-16-1908</u>	
8. BIRTHPLACE (State or Foreign Country) <u>N. Carolina</u>				9a. FACILITY NAME (If not institution, give street and number) <u>6901 Ridgeway</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Dundalk</u>	
9c. COUNTY OF DEATH <u>Baltimore</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>	
10c. CITY, TOWN OR LOCATION <u>Dundalk</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>6901 Ridgeway</u>	
10f. ZIP CODE <u>21222</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>N/A</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Ancel McKinney</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Biddie Mosley</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Virginia Kiesling</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6901 Ridgeway Baltimore, Md. 21222</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u></u>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Trautman Cemetery</u> DATE <u>4-15</u>		20c. LOCATION — City or Town, State <u>Buladean, N. Carolina</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Anthony Colt Connelly</u>				22. NAME AND ADDRESS OF FACILITY <u>Connelly Funeral Home of Dundalk</u> <u>7110 Sollers Point Rd 21222</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ASCD</u> Approximate Interval Between Onset and Death <u>30 yrs</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u></u>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined 7 <input type="checkbox"/> Other (Specify) <u></u>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>David A. Goldscher</u>				29c. LICENSE NUMBER <u>D16770</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/11/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>David A. Goldscher, M.D. 5601 Loch Raven Blvd Baltimore, Md 21239</u>							
31. DATE FILED (Month, Day, Year) <u>APR 11 1995</u>				32. REGISTRAR'S SIGNATURE <u>Jane [Signature]</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Replacement  
95 11080

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Weber				2. DATE OF DEATH MONTH DAY YEAR April 01 1995		3. TIME OF DEATH 1:30p.m.	
4. SOCIAL SECURITY NUMBER 218-03-9397		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 5, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not Institution, give street and number) Church Hospital Corp.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH —				10a. STATE Maryland		10b. COUNTY —	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 831 S. Montford Avenue	
10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Paint Mfg.			
17. FATHER'S NAME (First, Middle, Last) John Weber				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Krolczyk			
19a. INFORMANT'S NAME (Type/Print) Joseph Weber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 831 S. Montford Ave. Balto. Md. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 4/5/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond A. Weber (Pres.)</i> George A. Weber & Sons Inc.				22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bilateral Pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF):							
c. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
24. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Littel</i>				29c. LICENSE NUMBER D16188		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walker A. Impaglatelli 100 N. Broadway, Baltimore, Maryland 21231							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11081

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GUSTAV A. WILHELM</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>				3. TIME OF DEATH <b>8:57 A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-01-2437</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/15/1905</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH -----	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1446 Richardson Street</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Longshoreman</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Shipping</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Gustav Wilhelm</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Augusta Roesler</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Phillip L. Rausenberger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>610 Hilton Avenue, Catonsville, MD 21228</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Redeemer Cem, April 11, 1995 Maryland</b>			20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Victor P. Dade Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY ARREST</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>EMPHYSEMA</b> DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>P 08182</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. HARTNER, Mercy Medical Center</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






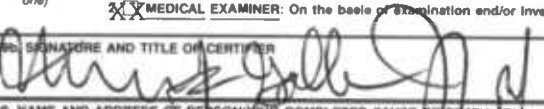
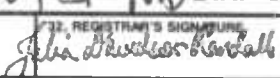
95-1881-510  
B.K.S

95 11082

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JANETTE WILSON</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>3</b> , YEAR <b>1995</b>				3. TIME OF DEATH <b>2115 P.M.</b>							
4. SOCIAL SECURITY NUMBER <b>216-74-8922</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>39</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>November 18, 1955</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>301 SOUTH WOODYEAR STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH <b>N/A</b>								
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
10e. STREET AND NUMBER <b>310 SOUTH WOODYEAR</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Food Service</b>								
17. FATHER'S NAME (First, Middle, Last) <b>William Alfred Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Donia Ethel Willis</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Samuel Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5322 Dogwood Rd., Baltimore, MD 21202</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery 4-7-95</b>		20c. LOCATION — City or Town, State <b>Ellicott City, MD</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CIRRHOSIS OF THE LIVER &amp; PNEUMONIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>CHRONIC ALCOHOLISM</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MARIO F. GOLIO, JR. MD</b>												29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 4, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIO, JR. MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>															
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11083

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lawrence M. Watkins, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4-09-1995</b>		3. TIME OF DEATH <b>6:05 P<sup>m</sup></b>	
4. SOCIAL SECURITY NUMBER <b>215-18-9844</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-27-1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Home, 2816 Huntingdon Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2816 Huntingdon Avenue</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mill Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Textile Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Jenkins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertie Lee Jenkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Lockhart</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 Rainbow Way Front Royal, VA 22630</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery 4/13</b>		20c. LOCATION — City or Town, State <b>Hampden, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry Henss Carpenter</i>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 3631 Falls Road Balto., MD 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Immediate</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Marshall</i>				29c. LICENSE NUMBER <b>D35363</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. Marshall MD BVAMC 10 N. Greene St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11084

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernard F. Williams</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-10-3668</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 11 - 1919 Washington D.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crofton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2518 Vineyard Lane</b>				10f. ZIP CODE <b>21114</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plumber</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Plumbing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Hayden</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sandra Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2518 Vineyard Lane, Crofton, MD 21114</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Veterans Cemetery 4/13</b>		20c. LOCATION — City or Town, State <b>Crownsville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas A. Hatcher</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b> <b>CHRONIC ALCOHOLISM</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death <b>20 DAYS</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Nizar Chirafedine</b>				29c. LICENSE NUMBER <b>D45484</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 9, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NIZAR CHIRAFEDINE NORTH ARUNDEL HOSP., MD 21061</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Hatcher</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

95 11085

1. DECEDENT'S NAME (First, Middle, Last) <b>BERTHA L Laboria White</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>05</b> YEAR <b>95</b>		3. TIME OF DEATH <b>0935P</b>	
4. SOCIAL SECURITY NUMBER <b>219-07-3544</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02/21/09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7900 Benesch Circle</b>	
10f. ZIP CODE <b>21060</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b></b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired Cook</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Tall Oaks Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Philip Tagliavia</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary LOPRESTI</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Ross F. White, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>819 Washburn Ave., Baltimore, Md. 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Pk., 4/10/95</b>			
20c. LOCATION — City or Town, State <b>Elkridge, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>			
22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, Md. 21122</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. C.O.P.D WITH RESPIRATORY FAILURE</b> <b>b. CONGESTIVE HEART FAILURE</b> <b>c. UPPER GI BLEEDING</b> <b>d.</b>			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MYOCARDIAL INFARCTION</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b></b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <b></b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Agustin MEDICAL HOUSE OFFICER</b>				29c. LICENSE NUMBER <b>0439177</b>			
29d. DATE SIGNED (Month, Day, Year) <b>APRIL 5th 95.</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>OLEZONT, Agustin, NORTH ARUNDEL HOSP. 301 HOSP. DRIVE GLEN BURNIE MD.</b>			
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11086

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DARRYL RODNEY WILSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 06, 1995</b>		3. TIME OF DEATH <b>1:24 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>213-88-7630</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 18, 1962</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE, MD</b>				9. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				11. COUNTY OF DEATH <b>n/a</b>			
12. STATE <b>MARYLAND</b>		13. COUNTY <b>n/a</b>		14. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
16. STREET AND NUMBER <b>1212 PEARLEAF COURT</b>				17. ZIP CODE <b>21202</b>		18. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
19. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (13-16 or 17+) <b>-</b>		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unemployed</b>		25. KIND OF BUSINESS/INDUSTRY <b>n/a</b>			
26. FATHER'S NAME (First, Middle, Last) <b>ROBERT WILSON</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ETHEL DAVIS</b>			
28. INFORMANT'S NAME (Type/Print) <b>ETHEL ANDERSON</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1212 PEARLEAF COURT, BALTIMORE, MD 21202</b>			
30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHELL MEMORIAL GARDENS 4-12 DUNDALK, MD</b>		32. DATE <b>4-12-95</b>		33. LOCATION — City or Town, State	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				35. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Hypothermia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>AIDS</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
36. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
38. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY <b>M</b>		41. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				43. DESCRIBE HOW INJURY OCCURRED			
44. LOCATION (Street and Number or Rural Route Number, City or Town, State)				45. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>L4817</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. WILLIAMS MD 600 N. Wolfe Street Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11087

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ernestine - Washburn</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-12-8232</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/10/19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Manor Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4615 PARK HEIGHTS AVENUE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>UNK</b> College (1-4 or 5+) <b>UNK</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SOCIAL SERVICES ADMINISTRATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALICE BELLAMY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>861 PARK AVE. BALTIMORE, MD. 21201</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 04-11-95</b>		20c. LOCATION — City or Town, State <b>LANSDOWNE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ALBERT P. WYLIE F/A PA. 638 N. GILMOR STREET 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>arterosclerotic Heart Disease</b>					Approximate Interval Between Onset and Death <b>2 years</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Chronic obstructive lung disease: chronic bronchitis</b>					<b>3 years</b>
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		e. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		26d. DESCRIBE NOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Manuel Levin M.D.</b>				29c. LICENSE NUMBER <b>005622</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Manuel Levin, M.D. 6101 Park Heights Ave. Baltimore MD. 21215</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11088

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA A. WASHINGTON</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:25 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-48-2211</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 30, 1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH <b>n/a</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>924 E. PRATT STREET</b>			
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 TH</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DATA OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DEPT. of SOCIAL SERVICES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT PARKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY WATERS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBIN S. WASHINGTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>924 E. PRATT STREET, BALTIMORE, MD 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 4-13</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>		20d. DATE <b>4-13</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dee V. Holland</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RECURRENT CERVICAL CANCER</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>RENAL FAILURE</b> Due to (or as a consequence of): c. <b>SEPSIS</b> Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Tracy E. Dulke, M.D.</b>				29c. LICENSE NUMBER <b>P0862</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TRACY E. DULKE, M.D., UMMS, 22 S. GREENE ST., BALTIMORE, MD</b>							
31. REGISTRAR'S SIGNATURE <b>John [Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

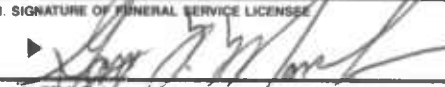
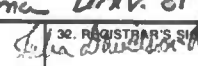
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11089

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louise Williams</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>6</b> YEAR <b>95</b>		3. TIME OF DEATH <b>12:35 P.</b>	
4. SOCIAL SECURITY NUMBER <b>214-38-0904</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 30, 1940</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD.</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2011 W. LEXINGTON ST.</b>			
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE—American Indian, Black, White, etc. <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MASS TRANSIT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>NATHANIEL Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BERNEATHA BENJAMIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William WOOTEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2803 WINDSOR AVE. BALT. MD. 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FLORIAN PARK 4/11/95 BALTIMORE MD.</b>		20c. LOCATION—City or Town, State <b>BALTIMORE MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FUNERAL HOME <b>GARY T. MARCH FUNERAL HOME INC. 2707 FREDERICK PASS BALT. MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Sarcoidosis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Stroke</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Enterococcal Urinary Tract infection</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate Interval Between Onset and Death <b>3 days</b> <b>Years</b> <b>One month</b> <b>One Week</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>n/a</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Chehrem D.O.</b>				29c. LICENSE NUMBER <b>D40499</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. M. Chehrem Univ. of MD. Neurology Dept Baltin. MD. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11090

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSE				2. DATE OF DEATH MONTH DAY YEAR APRIL 6, 1995				3. TIME OF DEATH 7:30am	
4. SOCIAL SECURITY NUMBER 212-22-9913		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MARCH 3, 1903	
9a. FACILITY NAME (If not institution, give street and number) PIKESVILLE NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3601 FORDS LANE, APT. 621				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESPERSON		16b. KIND OF BUSINESS/INDUSTRY LADIES CLOTHING			
17. FATHER'S NAME (First, Middle, Last) PHILIP JACOBSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) MRS. MOLLIE BROOKS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 147 HORWICH, VT. 05055					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW YOUNG MENS- 4-9-1995		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D. Lewis</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pulmonary Embolism</i>									
Due TO (OR AS A CONSEQUENCE OF): b. <i>Thrombophlebitis</i>									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. Due TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>Acute</i> <i>3 weeks</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic cardiovascular Disease</i> <i>Diabetes</i>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sheldon Goldberger</i>				29c. LICENSE NUMBER D0 2397		29d. DATE SIGNED (Month, Day, Year) April 6, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sheldon Goldberger 4000 Old Court Road Pikesville MD 21208</i>									
31. DATE FILED (Month, Day, Year) APR 11 1995 <i>Jabin [Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11091

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JESSIE W. BOWEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 7, 1995</b>		3. TIME OF DEATH <b>6:24 a.</b>	
4. SOCIAL SECURITY NUMBER <b>217-09-5592</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-2-11</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1104 Taylor Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Arbutus</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Arbutus</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1104 Taylor Avenue-Arbutus, Md.</b>			
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>N/A</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Saleslady</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dept. Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wade H. Payne</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Allison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Herman W. Payne</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2401 Smith Avenue-Baltimore, Md. 21227</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Warrenton Cemetery 4-10-95</b>		20c. LOCATION — City or Town, State <b>Warrenton, Va.</b>		20d. DATE <b>4-10-95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>5151 Baltimore National Pike Baltimore, Md. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Colon Carcinoma</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Edmund P. Thacker</b>				29c. LICENSE NUMBER <b>D34951</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-7-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edmund P. Thacker 405 Federal Rd Suite 100 Cockeville TN 38220</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>John W. Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11092

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NATHANIEL BROWN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>22:47 P M</b>	
4. SOCIAL SECURITY NUMBER <b>250-30-8858</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-16-24</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3010 Oak Green Ct.-Ellicott City, Md.</b>				10f. ZIP CODE <b>21042</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Counselor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Linda Harden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3010 Oak Green Ct.-Ellicott City, Md. 21042</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 4-10-95 Balto., Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>5151 Baltimore National Pike Baltimore, Md. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>coronary artery disease</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death <b>1 hour</b> <b>2 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Lymphocytic Leukemia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Salma B. Osborne, MD</b>				29c. LICENSE NUMBER <b>D46325</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>St. Agnes Hospital 900 CATON AVENUE BALTIMORE, MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11093

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Delta E. Brockett</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>23</b> YEAR <b>95</b>		3. TIME OF DEATH <b>11:50p</b>	
4. SOCIAL SECURITY NUMBER <b>215 16 2058</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>8/30/21</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTO. CITY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3400 HILLDALE PLACE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>AFR. AMERICAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES GROSS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH GROSS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE S. BROCKETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3400 HILLDALE PLACE BALTO. MD. 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CROWNSVILLE V.A. 3/30/95</b>		OATE <b>CROWNSVILLE, MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Leah A. Estep</b>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple System Organ Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. End Stage Renal Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stephen T. Bartlett</b>				29c. LICENSE NUMBER <b>141332</b>		29d. DATE SIGNED (Month, Day, Year) <b>4.10.95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen Bartlett 22 S. Greene St.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Anderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11094

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWARD O. BURAKOWSKI</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:05 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>047-12-0214</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 25, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Pikesville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>26 Waldron Ave.</b>	
10f. ZIP CODE <b>21208</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Crown Cork and Seal</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. and Mrs. Emmerton Ritter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26 Waldron Ave. Pikesville, MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery 4/13</b>		20c. LOCATION — City or Town, State <b>Woodlawn, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Corey</i>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>PNEUMONIA</b>							
Approximate Interval Between Onset and Death <b>2 days</b> <b>2 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ESRD, CHF, IDDM, COPD</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Imperial, Jr.</i> M.D.				29c. LICENSE NUMBER <b>044505</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.J. IMPERIAL, JR., NORTHWEST HOSPITAL CENTER</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1071VA



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE EVELYN BUJNOWSKI				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 10 - 10 AM	
4. SOCIAL SECURITY NUMBER 215-14-0152		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 14, 1910	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 1700 MERIDENE DR. APT. 307		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1700 MERIDENE DR. APT. 307	
10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABILITY CLAIMS REP.		16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY ADMIN.	
17. FATHER'S NAME (First, Middle, Last) WILLIAM T. GINGRICH				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVELYN AGNES HORRIGAN			
19a. INFORMANT'S NAME (Type/Print) JOSEPH BUJNOWSKI				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 MERIDENE DR. APT. 307 BALTIMORE, MD. 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE 4/13/95		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CAD. (myocardial infarction) DUE TO (OR AS A CONSEQUENCE OF): b. atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DM DUE TO (OR AS A CONSEQUENCE OF): d. Peripheral Vascular Disease Approximate Interval Between Onset and Death a. 1 day b. 2 yrs. c. 2 yrs. d. 2 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John E. Dolan</i>				29c. LICENSE NUMBER D 22652		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SUBRAMANIAN SRINIVAS 5601 LOCH RAVEN BLVD. SUITE 206 BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John E. Dolan</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11096

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>AUDREY P. BOSLEY</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>7</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1235 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-03-2357</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 4, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Horizon N.H.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD.</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3107 FOSTER AVE.</b>			
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>PROOF READER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HENRY BOSLEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RACHEL HOLT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RACHEL DEERE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 HAMMARLEE RD. GLEN BURNIE, MD. 21060</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>GLEN HAVEN MEM. PARK 4-10-95 GLEN BURNIE, MD.</b>		20c. LOCATION — City or Town, State <b>BALTO., MD. 21224</b>		20d. ADDRESS OF FACILITY <b>2829 HUDSON ST.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Phuong J. Skarda Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>SKARDA F.H. 2829 HUDSON ST.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death <b>6 Months</b> <b>5 Years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D38675</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11097

ITEM: 5. PER F.H. FILM G-722 4/19/95 t.t

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES ALLEN BAKER SR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR 9 1995</b>		3. TIME OF DEATH <b>2307 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-20-3068</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 27, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTO., MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MERIDIAN SEVERNA PARK NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SEVERNA PARK</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>ARBUTUS</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1243 POPLAR AVENUE</b>	
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during past of working life. Do NOT use retired.) <b>TECHNICIAN ENGINEERING</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WESTINGHOUSE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>DR. JAMES H. BAKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BLANCHE SOPHIE SCHLOSSER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. DEBRA A. HOLUB</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1496 ASCOT DRIVE - PASADENA, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PARK 4/13</b>		20c. LOCATION — City or Town, State <b>ELKRIDGE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie D. Shannon</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC LUNG CARCINOMA</b> Approximate Interval Between Onset and Death <b>12 MONTHS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending</i>				29c. LICENSE NUMBER <b>D21776</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA P. MUNDRA MD 203 E PARAYSCOAV, BALTIMORE MD 21222</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Kroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11098

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Carl Bygler</i>				2. DATE OF DEATH MONTH <i>03</i> DAY <i>23</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1:45 p</i> M	
4. SOCIAL SECURITY NUMBER <i>713-10-3778</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>89</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>02/15/06</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1300 S. ELLWOOD AVENUE</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 YEARS</i> College (1-4 or 5+) <i>COLLEGE</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MACHANIST</i>		16b. KIND OF BUSINESS/INDUSTRY <i>RAILROAD</i>			
17. FATHER'S NAME (First, Middle, Last) <i>UNKNOWN</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>UNKNOWN</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MS. DONNA YORKSTER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1300 S. ELLWOOD AVENUE BALTO., MD. 21224</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GREENMOUNT CEMETERY</i> DATE <i>3-31</i>		20c. LOCATION — City or Town, State <i>BALTO. CITY MD.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chuck Kaczorowski</i>				22. NAME AND ADDRESS OF FACILITY <i>KACZOROWSKI FUNERAL HOME</i> <i>1201 DUNDALK AVENUE BALTO., MD. 21224</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Failure</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Colon Carcinoma with Metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>						Approximate interval Between Onset and Death <i>days</i> <i>Years</i>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>N/A</i> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>N/A</i>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald T. H. M.D. Resident</i>				29c. LICENSE NUMBER <i>P08176</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/23/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John P. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


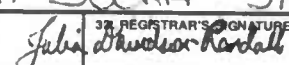
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kathleen M. Britt</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>3</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-26-8449</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 9, 1929</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>1253 Poplar Avenue</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Arbutus</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Arbutus</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1253 Poplar Avenue</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wilmoth Coale Weaver</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marquerite Clara Hauser</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Martin P. Britt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1253 Poplar Avenue, Arbutus, MD 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Louden Park Cemetery</b>		DATE <b>4/7/95</b>		20c. LOCATION — City or Town, State <b>Ba</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PNEUMONIA</b>					Approximate Interval Between Onset and Death <b>24 Hrs</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>Multiple Sclerosis</b>					<b>14 yrs.</b>
		c. _____					
		d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Barbara Socha, M.D.</b>				29c. LICENSE NUMBER <b>D35609</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Barbara Socha 516 N. Rolling Rd. Baltimore MD 21228</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 1. PER F.H. FILM G-722 4/17/95 t.t  
Item 1, g-722, 4-12-95, per f.h., dk

95 11100

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Basil Basili</u> A.K.A. <u>Basili Basilio</u>		2. DATE OF DEATH MONTH <u>April</u> DAY <u>11</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>2:00 P.</u> M
4. SOCIAL SECURITY NUMBER <u>066-09-7883</u>	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>90</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>May 11, 1904</u>	8. BIRTHPLACE (State or Foreign Country) <u>Italy</u>
9a. FACILITY NAME (If not institution, give street and number) <u>Charlestown Care Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Catonsville</u>		9c. COUNTY OF DEATH <u>Baltimore</u>
RESIDENCE OF DECEDENT				
10a. STATE <u>Maryland</u>	10b. COUNTY <u>Baltimore</u>	10c. CITY, TOWN OR LOCATION <u>Catonsville</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <u>711 Maiden Choice Lane</u>		10f. ZIP CODE <u>21228</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12</u> <u>College (1-4 or 5 +)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Salesman</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Paper Products</u>
17. FATHER'S NAME (First, Middle, Last) <u>Dominic Basili</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Settimia Ugolineli</u>		
19a. INFORMANT'S NAME (Type/Print) <u>Victor Basili (Son)</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13716 Bridgewater Drive Silver Spring, Maryland 20904</u>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>New Cathedral Cemetery April 13, 1995</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>L. W. Witzke</u>		22. NAME AND ADDRESS OF FACILITY <u>Leroy M &amp; Russell C Witzke Funeral Homes</u> <u>1630 Edmondson Avenue Catonsville Maryland</u>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <u>M</u>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Sharon J. McConnel MD</u>		29c. LICENSE NUMBER <u>038762</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/11/95</u>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>711 Maiden Choice Lane Baltimore, Md</u>				
31. DATE FILED (Month, Day, Year) <u>APR 12 1995</u>		32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached from the original and submitted to the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11101

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Matilda D. Bunesch</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 9, 1995</i>		3. TIME OF DEATH <i>8:30 A M</i>	
4. SOCIAL SECURITY NUMBER <i>214-54-7044</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>95</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan, 25, 1900</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>3126 Dubois Ave.</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Balto.</i>		8c. COUNTY OF DEATH <i>Balto.</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Balto.</i>		10c. CITY, TOWN OR LOCATION <i>Balto.</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3126 Dubois Ave.</i>				10f. ZIP CODE <i>21234</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i>Homemaken</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaken</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Albert Duban</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Caroline Melihan</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Miss Jean M. Bunesch</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3126 Dubois Ave. Balto., Md. 21234</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Bohemian National Cem. 4/10 Balto., Md.</i>		20c. LOCATION — City or Town, State		20d. DATE <i>4/10 Balto., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joy D. Smith</i>				22. NAME AND ADDRESS OF FACILITY <i>Hartley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion Kowalewski</i>				29c. LICENSE NUMBER <i>021022</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-10-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARION KOWALEWSKI 8604 HARPORN Rd</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



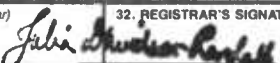
IMPORTANT: If item 28 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH CONWELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7 1995</b>		3. TIME OF DEATH <b>8:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>062-09-5643 A</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 25, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>IRVINGTON KNOLL NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10. RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2560 Arunah Avenue</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School Grad</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>I L G W U</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HENRY WESSLES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE Maddox</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edna Ruff</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2560 Arunah Avenue Balt, Md. 21216</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fairview AME Church Cem. 4/11</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Balt. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute myocardial infarction suspected</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Atherosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Coronary heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Emphysema, Paget's disease, Dementia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30494</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>* DESHAW 4660 Wilkens Ave Baltimore MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



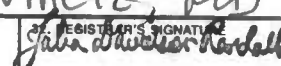


95 11103

Item 7, g-722, 4-12-95, per f.h., dk

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA CARTER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 6 1995</b>		3. TIME OF DEATH <b>12:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-84-2952</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 4 1961</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MC.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1217 Argyle Avenue</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (14 or 5+) <b>Waitress</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lee Carter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Boderick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cindy Carter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1112 East Pratt St. Baltimore, Md. 21202</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>Mt. Zion Cemetery 4/11/95</b>		20c. LOCATION — City or Town, State <b>Lansdowne, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Cable Funeral Service 5502 Winner Avenue Balto, Md. 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Uremia</b>							
b. <b>acquired immunodeficiency syndrome</b>							
c. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>							
d. <b>Due to (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>045746</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph M. Vinetz, MD Johns Hopkins Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David Carr</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>7</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>6:54 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>237-36-5368</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>67</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 14, 1927</i>	
8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>2703 Belvedere Ave.</i>	
10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5</i> College (1-4 or 5+) <i>0</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Construction</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Allen L. Carr</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ressie Britt</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Beverly Black</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3423 Russelwood Dr. Rockford Tn. 37853</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematorium, or other place) <i>Oak Ridge Cemetery 4/13/95</i>		20c. LOCATION — City or Town, State <i>Weldon, N.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>brain herniation</i>				Approximate Interval Between Onset and Death <i>1 day</i>	
		b. <i>cerebellar hemorrhage</i>				<i>3 wks</i>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. <i>hypertension</i>				<i>30 yrs</i>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>E+OH UR</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Surgical Resident</i>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan Dardik MD</i>				29c. LICENSE NUMBER <i>AS2402321 AD7622</i>			
29d. DATE SIGNED (Month, Day, Year) <i>4/7/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alan Dardik MD Sinai Hospital</i>			
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>William Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11105

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Raymond Edward Christian</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0940</b>	
4. SOCIAL SECURITY NUMBER <b>219-70-3488</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs., last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/30/56</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>AA Co. Detention Ctr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>	
9c. COUNTY OF DEATH <b>AA</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO				10e. STREET AND NUMBER <b>604 Lyndhurst St.</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unemployed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Sidberry</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Christian</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lorraine Judkin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1613 Dukeland St. Balto, Md. 21216</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Mt. Zion 4/13/95</b>		20c. LOCATION — City or Town, State <b>Lansdowne, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto., Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent Pneumonia</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> OOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>Detention Ctr.</b>			
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William P. Jones, MD</b>				29c. LICENSE NUMBER <b>DO6054</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones, MD</b>				31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>			
32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>				33. ADDRESS OF REGISTRAR <b>695 America 21035</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11106

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William E. Cannow, Sr.</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 10, 1995</i>		3. TIME OF DEATH <i>8:30 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-30-8220</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>August 12, 1934</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>8 N. East Ave.</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>8 N. East Ave.</i>	
10f. ZIP CODE <i>21224</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i>N/A</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Painter</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Construction</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Theodore Cannow</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mildred Savage</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Milton T. Cannow</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1606 Chesaco Ave. Balto., Md. 21237</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gardens of Faith Cem. 4/13 Balto., Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive Cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>M</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D06776</i>			
29d. DATE SIGNED (Month, Day, Year) <i>4/17/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>IRVIN D. KAPLAN MD 129 S BROADWAY BALTO MD 21201</i>			
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11

7

\*

C

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANKLIN ROOSEVELT DARBY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>5</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-42-7904</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 13 1945</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>919 PARRISH STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>N/a</b>	
10c. CITY, TOWN OR LOCATION <b>BALTO</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1944 HARLEM AVE</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BARBER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BARBER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH DARBY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH NEWSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RUTHIE WEEKS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1944 HARLEM AVE BALTO, MD 21217</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other facility) <b>WESTERN STAR CEMETERY</b>		DATE <b>4/3/95</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH F/H -WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND ON 4/5/95</b>		28b. TIME OF INJURY <b>7:30 A M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1944 HARLEM AVE. BALTIMORE, MD.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 5, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John F. Davis Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>				3. TIME OF DEATH <b>00:30 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>265-18-6353</b>				5. SEX <b>M</b> <input type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 3, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>Florida</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3500 Howard Park Ave</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>			9c. COUNTY OF DEATH <b>N/A</b>				
10a. STATE <b>Md</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3500 Howard Park Ave</b>						10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (14 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Foreman</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Longshoreman</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Tom J. Davis</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nora Davis</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy J. Davis</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3500 Howard Park Ave Balto, Md 21207</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>				20c. LOCATION — City or Town, State <b>Balto, Md</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jerome A. Thompson Jr.</b>						22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Wabash Ave</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular accident</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death <b>4 years</b> <b>10 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>gastrostomy tube feedings 2° dysphagia, decubitus ulcer</b>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Timothy J. Keay, M.D.</b>				29c. LICENSE NUMBER <b>D37458</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Timothy J. Keay, M.D. Kernan Housecall Program, 2200 N. Forest Park Ave. Balt., Md.</b>													
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>James A. Randall</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


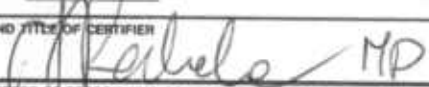

5-10A



95 11109

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Nellye A. Doering</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2050</b>	
4. SOCIAL SECURITY NUMBER <b>212-07-0391</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 20, 1901</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6234 GILSTON PARK ROAD</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HAMILTON MERRYMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MOLLIE FOSTER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LORETTA RIMANDO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6234 GILSTON PARK ROAD-CATONSVILLE, MD 21228</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PARK 4/11</b>		20c. LOCATION — City or Town, State <b>ELKRIDGE</b>		20d. DATE <b>4/11</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Septis</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval between Onset and Death <b>1 day</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>3 days</b>	
		c. <b>Alzheimer disease</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>10 yrs.</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D-45186</b>		29d. DATE SIGNED (Month, Day, Year) <b>APR 8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K. RACHOCKA, 800 CANTON AVE, BALTO, MD 21228</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12





95 11110

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dellie Ewell				2. DATE OF DEATH MONTH DAY YEAR April 5, 1995		3. TIME OF DEATH 7:55 A M	
4. SOCIAL SECURITY NUMBER 101-18-1875		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 28, 1915	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Md. General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1815 Ruxton Ave.	
10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13-16) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory Worker		16b. KIND OF BUSINESS/INDUSTRY Private Industry	
17. FATHER'S NAME (First, Middle, Last) George Wood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Shark			
19. INFORMANT'S NAME (Type, Print) Esther Riggs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 Ruxton Ave. Balto. Md. 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star 4/10/95		20c. LOCATION — City or Town, State Balto. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ				22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cachexia Malignancy							
b. Intra-abdominal Desmoid Tumor							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. clinical Sepsis							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined							
28a. DATE OF INJURY (Month, Day, Year)							
28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Stella L. Thalhamer							
29c. LICENSE NUMBER 89222							
29d. DATE SIGNED (Month, Day, Year) April 5, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stella Thalhamer, M.D. c/o Maryland General Hospital							
31. DATE FILED (Month, Day, Year) APR 12 1995							
32. REGISTRAR'S SIGNATURE Julia Davidson Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11111

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry A. Evans, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 5 1995		3. TIME OF DEATH 7:55 P M	
4. SOCIAL SECURITY NUMBER 216-20-5870		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 5, 1925 Maryland	
9a. FACILITY NAME (If not institution, give street and number) FORT HOWARD VAMC RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1202 N. Augusta Avenue				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Picture Frammer - Artist		16b. KIND OF BUSINESS/INDUSTRY TownHouse Framers			
17. FATHER'S NAME (First, Middle, Last) Harry A. Evans Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Davis			
19a. INFORMANT'S NAME (Type/Print) Suzanne Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 N. Augusta Ave. Baltimore, Maryland 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery 4/11		20c. LOCATION — City or Town, State Owings Mills, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Prasad R. Nataraj				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes Inc. 2501 Gwynn Falss PKY Balt. Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Prasad Nataraj				29c. LICENSE NUMBER 09315R		29d. DATE SIGNED (Month, Day, Year) 4/5/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR PRASAD NATARAJ---9600 NORTH POINT ROAD, FORTHOWARD, MARYLAND 21052							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE John Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1991-510

blh

95 11112

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Eleazar Floyd</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 08 1995</b>		3. TIME OF DEATH <b>1232</b> M	
4. SOCIAL SECURITY NUMBER <b>244-44-4481</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 9 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4020 Grantley Road</b>	
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean Conflict</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>Brick Mason</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Brick Mason</b>				16b. KIND OF BUSINESS/INDUSTRY <b>D&amp;D Contractor</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Junuis Floyd</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mamie Thompson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Selena Floyd</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3602 Erdman Avenue Baltimore, Maryland 21213</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD Veteran Cemetery/Garrison Apr 13</b>			
20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Herbert E. Nutt</b>			
22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mario E. Colle, Jr., MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 09 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mario E. Colle, Jr., MD, 11 Penn Street, Baltimore Maryland 21201</b>				31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>			
32. REGISTRAR'S SIGNATURE <b>John B. ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11113

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EARL EUGENE FINK</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>2:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-07-3567</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 17, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>5933 Bertram Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5933 Bertram Ave</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II Army</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receiving Supervisor</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Furniture Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Fink</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sophia Klima</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Anna L. Fink</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5933 Bertram Ave. Baltimore, Maryland 21214</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		DATE <b>4-14-95</b>		20c. LOCATION — City or Town, State <b>Parkville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark T. Zavoyna</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerosis coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Marion Kowalewski M.D.</b>				29c. LICENSE NUMBER <b>A21022</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marion Kowalewski, M.D. 8604 Harford Road Parkville, Maryland 21234</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

13

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11114

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA FITZGERALD</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:59</b> <b>A</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>Unknown</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 28, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bay Meadows Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1055 Stoll Place</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>David Bryant</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris Showacre</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2020 Sulphur Spring Rd., Halethorpe, MD 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crest Lawn Memorial Gardens</b>		DATE <b>4/12</b>		20c. LOCATION — City or Town, State <b>Marietta, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ambrose F.H. of Lansdowne</b> <b>2719 Hammonds Ferry Rd., Lansdowne, MD 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>RENAL FAILURE</b>				Approximate interval Between Onset and Death <b>XLS</b>	
		b. <b>ASCID</b>				<b>YLS</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>DIABETES</b>				<b>YLS</b>	
		d. <b>HYPERTENSION</b>				<b>YLS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>020333</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/19/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K. JONES 1777 KENTTOWN RD BALT 21208</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joan Ford</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>2</i> YEAR <i>95</i>				3. TIME OF DEATH <i>12 10 P M</i>							
4. SOCIAL SECURITY NUMBER <i>213-24-0777</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>4-19-28</i>		8. BIRTHPLACE (State or Foreign Country) <i>NY</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>na</i>					
RESIDENCE OF DECEDENT															
10a. STATE <i>Maryland</i>		10b. COUNTY <i>na</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>514 Meadows Road</i>				10f. ZIP CODE <i>212067</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOSTESS</i>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <i>EARNEST W. VEIRA</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARIE McCUTHEON</i>									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>In state removal</i>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</i>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Gastro-intestinal bleeding</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <i>Peptic ulcer disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Hepatic cirrhosis</i> c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hepatic c. crisis, Thrombocytopenia</i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joan Kaplan MD</i>						29c. LICENSE NUMBER <i>P0887</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/2/95</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mary Medical Center, 301 St Paul St Baltimore, MD 21202</i>															
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


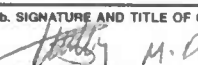
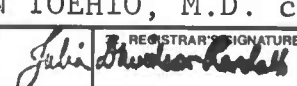
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11116

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAWRENCE HEARN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7, 1995</b>		3. TIME OF DEATH <b>1:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>220-36-9095</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>July 25, 1940</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4416 Kathland Avenue</b>			
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School Graduate</b> College (1-4 or 5+) <b>Orderly</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Orderly</b>		16b. KIND OF BUSINESS/INDUSTRY <b>University of Maryland Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Hearn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sallie Nollie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sally Carter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4416 Kathland Ave. Balt. Md. 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		DATE <b>4/12/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Balt. Md. 21216</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Terminal ACQUIRED IMMUNODEFICIENCY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>SYNDROME</b> Approximate interval Between Onset and Death <b>years</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>M.D.</b>				29c. LICENSE NUMBER <b>89230</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-7-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RUBY JEAN TOEHIO, M.D. c/o MARYLAND GENERAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11117

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAFFIE Houston</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 4th 1995</b>		3. TIME OF DEATH <b>7:15 P M</b>					
4. SOCIAL SECURITY NUMBER <b>254-16-3475</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 15, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2904 W. Mosher St.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School Grad</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Eddie Miller</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Armetta Jackson</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Anthony DeShields Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2904 W. Mosher St. Balt. Md. 21216</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore, National 4/11</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin Parker</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc. 2501 Gwynn Falls Pky Balt. Md. 21216</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG Cancer</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Respiratory Failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Terance L. Adams</b>				29c. LICENSE NUMBER <b>D37203</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 4th 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Terance L. Adams no Liberty Medical Center, Baltimore, Md. 21215</b>											
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Hudson-Rodell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) WALTON Leelando HART				2. DATE OF DEATH MONTH DAY YEAR APRIL 09 1995		3. TIME OF DEATH 1:45 A M	
4. SOCIAL SECURITY NUMBER 220-86-1404		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 21 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 21 1971	
8. FACILITY NAME (If not Institution, give street and number) 4506 WESTCHESTER AVE APT #B				9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		10. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4206 Westchester Road				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self employed		16b. KIND OF BUSINESS/INDUSTRY self employed			
17. FATHER'S NAME (First, Middle, Last) Walter Hart				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sheila Hart			
19a. INFORMANT'S NAME (Type/Print) Sheila Hart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4240 Bonner Road Apt 6 Baltimore, Maryland 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Zion Cemetery		20c. LOCATION — City or Town, State Apr 14 Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Gunshot Wounds a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-9-95		28b. TIME OF INJURY 1:35 AM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) building		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4506 Westchester Rd Baltimore City, MD	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Christie				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 09, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 N. PENN ST. BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE John D. ...					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2003-510

B.K.S

Item 20b &amp;c, g-722, 4-12-95, per f.h., dk

95 11119

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DAVID HAMLIN				2. DATE OF DEATH APRIL 9, 1995		3. TIME OF DEATH 1705 P M	
4. SOCIAL SECURITY NUMBER 214-44-1579		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-8-1946	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL E.R.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH N/A				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4443 Eldone Rd.	
10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Youth Supervisor		16b. KIND OF BUSINESS/INDUSTRY Juvenile Services State			
17. FATHER'S NAME (First, Middle, Last) David E. James				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jessie Hamlin			
19a. INFORMANT'S NAME (Type/Print) Annie Hamlin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4443 Eldone Rd. Balto., Md. 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of King Arbutus Memorial Park 4-15		20c. LOCATION — City or Town, State Woodlawn Baltimore Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Derrick C. Jones				22. NAME AND ADDRESS OF FACILITY Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 15			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> inspection							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE John D. Rensell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-5000

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11120

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thelma A. Hetrick</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>9</i> YEAR <i>95</i>		3. TIME OF DEATH <i>9:50 P M</i>	
4. SOCIAL SECURITY NUMBER <i>215-10-9108</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 16, 1916</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not Institution, give street and number) <i>Charlestown Care Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Pikesville</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>225 Brightside Ave.</i>	
10f. ZIP CODE <i>21208</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (9-12)</i> <i>10th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Retired Vault Attendant</i>		16b. KIND OF BUSINESS/INDUSTRY <i>MD National Bank</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Dunn</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertie E. Allen</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Patricia Nicholson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>221 Brightside Ave. Pikesville, MD 21208</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery</i>		DATE <i>4/13</i>		20c. LOCATION — City or Town, State <i>Woodlawn, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Cooney</i>				22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc.</i> <i>8728 Liberty Road Randallstown, MD 21133</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Dehydration and Anorexia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Dementia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>						Approximate Interval Between Onset and Death <i>2 weeks</i> <i>4 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Applebaum MD</i>		29c. LICENSE NUMBER <i>D34053</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/9/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gary Applebaum MD 711 Maiden Lane 21228</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVERETT L. JACKSON</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>08</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:35 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-78-2430</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>02 04 60</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>835 CLINTWOOD AVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>CITY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>107 Elizabeth Avenue</b>			
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1979 - 1985</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>1 year</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Carl Jackson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella Watson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Raye R. Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Gorsuch Ave. 2nd Fl Baltimore, Md 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crownsville Veterans 4/13</b>		20c. LOCATION — City or Town, State <b>Crownsville, Md</b>		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>William C. Brown Community Funeral Home 1206 W. North Ave. Balt. Md 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>SEIZURE DISORDER</b>							
b. <b>HEAD INJURY</b>							
c. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							
d. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>UNKNOWN</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 08, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>MARIO F. GOULO JR MD 111 N. PENN ST. BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

1 VA





95 11122

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary E. Jordan				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 9:54 A.M.	
4. SOCIAL SECURITY NUMBER 219-03-5621		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 11, 1921	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1917 Deering Avenue				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Josef Bender				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Novotny			
19a. INFORMANT'S NAME (Type/Print) Virginia M. Atkinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5951 Quinn Orchard Rd., Frederick, MD 21701			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Meadowridge Memorial Park 4/13		DATE 4/13		20c. LOCATION — City or Town, State Dorsey, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bowel Perforation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 8 days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Carcinoma							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 20281		29d. DATE SIGNED (Month, Day, Year) 4.10.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Max Wingerd MD 74 Thomas Johnson Drive, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11123

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARVIN A. LANGSTON</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>10</b> YEAR <b>95</b>		3. TIME OF DEATH <b>0730 AM</b>	
4. SOCIAL SECURITY NUMBER <b>245-10-6302</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 2, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>52 N. Ellamont Street</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. SA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4 or 5+) <b>NA</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore Contracting Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lewis Langston</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mittie Hunter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Pearly Langston</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>52 N. Ellamont Balto, Md 21229</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cem</b>		20c. DATE <b>4/13/95</b>		20d. LOCATION — City or Town, State <b>Balto, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thorne A. Thompson Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Wabash Ave Balto, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ischemic cardiomyopathy</b>					Approximate interval Between Onset and Death <b>&gt;5 years</b>
		b. <b>Coronary artery disease</b>					<b>&gt;10 years</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>ventricular tachycardia</b>					<b>5 months</b>
		d. <b>acute renal insufficiency</b>					<b>2 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>rectal bleeding, polyp of the colon</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.D.</b>				29c. LICENSE NUMBER <b>2063</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KASTURA ROBERT, ST. AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD, 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Hudson-Rodell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11124

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Evelyn Mary Levin</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10 1995</b>		3. TIME OF DEATH <b>1:40 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-5293</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 13, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center-Long Green</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4724 Hellwig Road</b>			
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Donald Skinner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Augusta Scheper</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Don Levin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4015 Jacinth Way Baltimore, Md. 21236</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Veteran's Cem. 4/13/95</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Earl L. Pange</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>4 days</b>						PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER'S DISEASE</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph W. Zerby</i>		29c. LICENSE NUMBER <b>D2233T</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11 '95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph W. Zerby 7801 YORK Rd TOWSON Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Hensel</i> <b>21204</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11125

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STEWART R. MARTIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 7, 1995</b>				3. TIME OF DEATH <b>1230 PM</b>	
4. SOCIAL SECURITY NUMBER <b>084-07-3356</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-13-07</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>331 Yale Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>331 Yale Avenue-Baltimore, Md.</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Executive</b>		16b. KIND OF BUSINESS/INDUSTRY <b>T.V. Company</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles L. Martin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Martin-Baker</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Robert Lee Martin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>377 Greenspring Rd.-Rt 5#-Hanover, Pa. 17331</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 4-8-95</b>		20c. LOCATION - City or Town, State <b>Balto., Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>3512 Frederick Avenue Baltimore, Md. 21229</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arterio sclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>2yr</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Esophageal Cancer</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wm. C. WATERFIELD MD</b>		29c. LICENSE NUMBER <b>024356</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wm. C. WATERFIELD MD St Agnes Hospital 860 Canton Ave Balt Md 21204</b>									
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Shuster-Ridell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11126

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Frank Myers</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:10A. M</b>	
4. SOCIAL SECURITY NUMBER <b>237-32-2720</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 16, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2302 N. Dukeland St</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2302 N. Dukeland St</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Police man</b>		16b. KIND OF BUSINESS/INDUSTRY <b>City Police Department</b>			
17. FATHER'S NAME (First, Middle, Last) <b>J. B. Myers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Altha Korie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jewell Myers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2302 N. Dukeland Balto Md 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery 4/10/95</b>		20c. LOCATION — City or Town, State <b>Balto, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Glynn B. Scott</b>				22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Wabash Ave Balto, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Carcinoma of Lung.</b>							Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Daliah Shawondeen MD</b>				29c. LICENSE NUMBER <b>D20252</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1940 W. Balto. St.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Gina H. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11127

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Clarence G. Mills</u>				2. DATE OF DEATH MONTH <u>APRIL</u> DAY <u>8</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>0440 A</u> M	
4. SOCIAL SECURITY NUMBER <u>249-01-0421</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>81</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 11, 1913</u>	
8. BIRTHPLACE (State or Foreign Country) <u>North Carolina</u>				9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>			
10b. COUNTY <u>N/A</u>				10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>1719 Edmondson Ave.</u>			
10f. ZIP CODE <u>21223</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Afro-Amer.</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u>0</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Steel Worker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Steel Mill</u>			
17. FATHER'S NAME (First, Middle, Last) <u>John Greene Mills</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Sarah Fair</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Lavinia M. Willis</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4725 Dunkirk Ave. Balto. Md. 21229</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Arbutus</u>		20c. LOCATION — City or Town, State <u>4/13/95 Balto. Co. Md.</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph L. Russ</u>	
22. NAME AND ADDRESS OF FACILITY <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CHF</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <u>Renal failure</u> b. <u>Due to (or as a consequence of):</u> c. <u>Due to (or as a consequence of):</u> d. <u>Due to (or as a consequence of):</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Lisa M. Kim</u>				29c. LICENSE NUMBER <u>2064</u>		29d. DATE SIGNED (Month, Day, Year) <u>APRIL 8, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>LISA M. Kim, St Agnes Hospital 900 S. Caton Ave. Balto, MD 21229</u>							
31. DATE FILED (Month, Day, Year) <u>APR 12 1995</u>				32. REGISTRAR'S SIGNATURE <u>John W. ...</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>HARRIET</del> Harritte Rosalie MCINTIRE				2. DATE OF DEATH MONTH DAY YEAR 04 06 1995		3. TIME OF DEATH 4:19 AM	
4. SOCIAL SECURITY NUMBER 216-34-2571		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 26, 1938	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL I.C.U.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lansdowne		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1712 Wilson Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Restaurant Manager		16b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Harry Newman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Graft			
19a. INFORMANT'S NAME (Type/Print) Sidney McIntire				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 337 Gatewater Court, Glen Burnie, MD 21060			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 4/8		20c. LOCATION — City or Town, State Catonsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose F.H. of Lansdowne 2719 Hammonds Fry. Rd., Lansdowne, MD 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ALCOHOLISM							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 06 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11129

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTHER MARY MOLINATTI</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>130-03-7406</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 3, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>California</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5905 Plumer Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5905 Plumer Ave.</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Clothing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Antonio Ravetto</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Felicina Allamanno</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Molinar</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4529 Raspe Ave., Baltimore, MD 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven</b>		DATE <b>4/13</b>		20c. LOCATION — City or Town, State <b>Hawthorne, NY</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Althaus</i>				22. NAME AND ADDRESS OF FACILITY <b>ALTENBURG FUNERAL HOME, P.A.</b> <b>6009 Harford Rd., Baltimore, MD 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIAC FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ISCHEMIC CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ANTI-ROSETTAL MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. CORONARY ARTERY DISEASE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>5mo</b> <b>5mo</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEVERE DEMENTIA</b> <b>SEVERE CHRONIC DEBILITATION</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Nicholas Goughman</i>				29c. LICENSE NUMBER <b>934041</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JELLES N. FONGA 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

JA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11130

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUTHER Mitchell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 6, 1995</b>		3. TIME OF DEATH <b>1100</b> M	
4. SOCIAL SECURITY NUMBER <b>214 10 9500</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-20-1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6960 Malta Avenue</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>43-46</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>William Edward Mitchell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Bounds Hearn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Sara Mitchell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6960 Malta Avenue, Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CONGESTIVE CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>YES</b> <b>YES</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SICK SINUS SYNDROME, PERMANENT, PACEMAKER, INSULIN DEPENDENT DIABETES</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. Chadnick</b>				29c. LICENSE NUMBER <b>P20912</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Dennis Chadnick - Quincy + Locust Str. Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11131

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>DANIEL NEAL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 8, 1995</b>		3. TIME OF DEATH HOURS MINUTES AM/PM <b>7:23 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-18-5368</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 11, 1919 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1631 Ruxton Ave.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gladys Neal</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1631 Ruxton Ave, Balto, Md. 21216</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Md. National 4/13/95</b>		20c. LOCATION — City or Town, State <b>Laurel, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
a. <b>Cardiac Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF):							20 mins
b. <b>Coronary Artery Bypass Graft</b> DUE TO (OR AS A CONSEQUENCE OF):							4 days
c. <b>Unstable Angina</b> DUE TO (OR AS A CONSEQUENCE OF):							6 months
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lung cancer, renal insufficiency, hypertension, non-insulin dependent diabetes mellitus, peripheral vascular disease</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David Kaufmann, MD</b>				29c. LICENSE NUMBER <b>JH # MS270</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David Kaufmann, MD, Johns Hopkins Hospital, Baltimore, Maryland 21287</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED NOWICKI				2. DATE OF DEATH MONTH DAY YEAR APRIL 05, 1995				3. TIME OF DEATH 1518 P.M.	
4. SOCIAL SECURITY NUMBER 218-22-9245		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 15, 1927		8. BIRTHPLACE (State or Foreign Country) MD.	
9a. FACILITY NAME (If not institution, give street and number) 5826 EAST AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE MD.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5826 EAST AVE.				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) MICHAEL Nowicki				18. MOTHER'S NAME (First, Middle, Maiden Surname) CECELIA WINIECKI					
19a. INFORMANT'S NAME (Type Print) EDWIN Nowicki				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3218 ELLIOTT ST. BALTO. MD. 21224					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEM. 4-8-95		20c. LOCATION — City or Town, State BALTO. MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda				22. NAME AND ADDRESS OF FACILITY SKARDA F.H. BALTO. MD. 21224 2829 HUDSON ST.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO partial	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas J. Skarda				29c. LICENSE NUMBER O.C.M.E				29d. DATE SIGNED (Month, Day, Year) APRIL 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201									
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE J. L. Hudson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11133

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Emile Pedersen</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 7, 1995</i>		3. TIME OF DEATH <i>7:00 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>224-52-8395</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>April 20, 1923</i>	
8. BIRTHPLACE (State or Foreign Country) <i>St. Croix</i>				9a. FACILITY NAME (If not institution, give street and number) <i>601 Longwood Street</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>NA</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>NA</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>601 Longwood Street</i>	
10f. ZIP CODE <i>21216</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12<sup>th</sup> grade</i> College (1-4 or 5+) <i>N/A</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Welder</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Welder for Longfence</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Peder Pedersen</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ann Petersen</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Evelyn Webster</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>601 Longwood Street Baltimore Md 21216</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest</i>			
20c. LOCATION — City or Town, State <i>4-148 Owings, Mills, Md.</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glenn A. Thompson Jr</i>			
22. NAME AND ADDRESS OF FACILITY <i>March funeral Home - West 4300 Wabash Avenue</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arrhythmia</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Arteriosclerotic Heart Disease</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>End stage Renal Disease</i> <i>Dementia</i>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>NA</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Juan A. Beltran MD</i>				29c. LICENSE NUMBER <i>16263</i>			
29d. DATE SIGNED (Month, Day, Year) <i>4/11/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Juan A. Beltran MD 1940 W. BALT. ST, BALT, MD 21223</i>			
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Thurston Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




5 + 1 RA





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JANE</b>		MARY JANE O'CONNOR POTTER		2. DATE OF DEATH MONTH DAY YEAR <b>Apr 10 1995</b>		3. TIME OF DEATH <b>11:55 pm</b>	
4. SOCIAL SECURITY NUMBER <b>218-32-6897</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-6-32</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Phoenix</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13713 Harcum Rd.</b>				10f. ZIP CODE <b>21131</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2 yrs</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edwin Gilbert O'Connor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leona Muth</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald R. Potter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13713 Harcum Rd. Phoenix, Md. 21131</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens 4-14</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>VENTRICULAR FIBRILLATION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>CHRONIC RENAL FAILURE</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
<b>ANOXIC ENCEPHALOPATHY</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>attending</b>				29c. LICENSE NUMBER <b>D 25686</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EBRAHIM IPAKCHI, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1 of 100

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

95 11135

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LORETTA</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> , 1995 YEAR				3. TIME OF DEATH <b>11:45PM</b> M							
4. SOCIAL SECURITY NUMBER <b>479-12-1721</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 2, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>DES MOINE, IOWA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>10524 BEECHWOOD DRIVE</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>WALDORF</b>				9c. COUNTY OF DEATH <b>CHARLES</b>					
RESIDENCE OF DECEDENT															
10a. STATE <b>MD.</b>		10b. COUNTY <b>CHARLES</b>		10c. CITY, TOWN OR LOCATION <b>WALDORF</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>10524 BEECHWOOD DR.</b>						10f. ZIP CODE <b>20601</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOME MAKER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>							
17. FATHER'S NAME (First, Middle, Last) <b>WILLARD AIKEN</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORENCE HILLARY</b>									
19a. INFORMANT'S NAME (Type/Print) <b>BARBARA KEENEY</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10524 BEECHWOOD DR. WALDORF, MD. 20601</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HIGHLAND MEM. GARDENS 4-12-95</b>				OATE		20c. LOCATION — City or Town, State <b>DES MOINE, IOWA</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas J. Skarda J.</b>						22. NAME AND ADDRESS OF FACILITY <b>SKARDA F.H. 2829 HUDSON ST. BALTO., MD 21224</b>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Viral pneumonia</b>															
a. DUE TO (OR AS A CONSEQUENCE OF):															
b. <b>respiratory insufficiency</b>															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DA Pace</b>						29c. LICENSE NUMBER <b>D-22574</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TIMOTHY R. PACE MD. WALDORF MEDICAL PARK P.O. BOX 249 WALDORF, MD 20604</b>															
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Juli Anderson</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME <b>Emma MAY Roth</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 07 1995</b>				3. TIME OF DEATH <b>8:43 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>UNKNOWN</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>4-25-12</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>21221</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>211 N. MARLYN AVENUE</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 YEARS</b> College (1-4 or 5+) <b>HOMEMAKER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SELF</b>					
17. FATHER'S NAME (First, Middle, Last) <b>LEWIS REITH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAGGIE MAY</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MRS. SHARON STACHOWSKI</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8168 DELHAVEN RD. BALTO. MD. 21222</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <b>GARDENS OF FAITH CEM 4-11</b>		20c. LOCATION — City or Town, State <b>BALTO. CO. MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczorowski</i>				22. NAME AND ADDRESS OF FACILITY <b>KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hypoxia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>PULMONARY EDEMA</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ANoxic BRAIN DAMAGE</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Asthma</b> Approximate interval between Onset and Death <b>20 hours</b> <b>20 hours</b> <b>20 hours</b> <b>20 hours</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Brian Ramza M.D. PhD</i>				29c. LICENSE NUMBER <b>M45467</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 7, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Brian Ramza 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>									
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000-  
W. V. Galt  
+

95 11137

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES F. SADLER, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 10, 1995</b>		3. TIME OF DEATH <b>7:22 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-72-6144</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-29-57</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>				9. COUNTY OF DEATH <b>N/A</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3527 Old Frederick Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			
10a. STATE <b>Md.</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3527 Old Frederick Rd.-Balto., Md.</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>Separated</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) <b>Set-Up Machine Worker-Md. Brush Co.</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>James F. Sadler, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elaine Rodgers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James F. Sadler, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3527 Old Frederick Rd.-Balto., Md. 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 4-12-95 Balto., Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>3512 Frederick Avenue Baltimore, Md. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, chronic anemia, Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>		29c. LICENSE NUMBER <b>D28236</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dorian St Martin MD 541 Old Frederick Rd Balto MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH REG. NO.

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

**TO THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas E. Stilling</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>8</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>M</b>							
4. SOCIAL SECURITY NUMBER <b>213-03-4984</b>		5. SEX <b>X</b> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 12, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>824 Sulphur Spring Rd.</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Arbutus</b>				9c. COUNTY OF DEATH <b>Baltimore</b>					
RESIDENCE OF DECEDENT															
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Arbutus</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>824 Sulphur Spring Rd.</b>						10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Warehouse Supervisor</b>				16b. KIND OF BUSINESS/INDUSTRY <b>A + D Grocery Stores</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Joseph E. Stilling</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora E. Haupt</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Stilling</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>824 Sulphur Spring Rd, Arbutus, MD 21227</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery 4/11 Baltimore, Maryland</b>				20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Paul Hagan</b>				22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Acute Renal Failure - Hepatorenal Syndrome</b> <b>END STAGE LIVER DISEASE</b> <b>HCV HEPATITIS</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ISCHEMIC HEART DISEASE</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>						29c. LICENSE NUMBER <b>D26 381</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Vijay Narayan, M.D. 3455 Wilkens Ave, suite LLS Baltimore, Maryland 21229</b>															
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

7 f 10A



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>JULIA A SLACUM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4 9 95</b>		3. TIME OF DEATH <b>7:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-20-1179</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>12/12/14</b>	
8. FACILITY NAME (If not institution, give street and number) <b>ST Elizabeth Nursing Home</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		10. COUNTY OF DEATH <b>N/A</b>	
11. STATE <b>Maryland</b>		12. COUNTY <b>N/A</b>		13. CITY, TOWN OR LOCATION <b>Baltimore</b>		14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
15. STREET AND NUMBER <b>3320 Benson Avenue</b>				16. ZIP CODE <b>21229</b>		17. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
18. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Line worker</b>		24. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>			
25. FATHER'S NAME (First, Middle, Last) <b>Joseph John House</b>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna A Roberts</b>			
27. INFORMANT'S NAME (Type/Print) <b>Beverly Harrison</b>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2923 Florida Avenue Balto, MD 21227</b>			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>metro crematory</b>		31. DATE <b>4/12/95</b>		32. LOCATION — City or Town, State <b>Catonsville</b>	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE 				34. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home 1328 Sulphur Spring Rd. Balto, MD 21227</b>			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Aspiration PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>SENIOR DEMENTIA ALZHEIMER TYPE</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
38. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				40. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
41. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		42. DATE OF INJURY (Month, Day, Year)		43. TIME OF INJURY <b>M</b>		44. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
45. DESCRIBE HOW INJURY OCCURRED				46. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
47. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER 				49. LICENSE NUMBER <b>D30182</b>		50. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM RUSSELL MD 3320 BENSON AVE BALT MD 21227</b>							
52. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		53. REGISTRAR'S SIGNATURE 					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11140

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Francis Suit 3'rd.				2. DATE OF DEATH April 9 <sup>th</sup> 1995		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 212-40-4248		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTHN (Month, Day, Year) March 27 42	
8a. FACILITY NAME (If not institution, give street and number) Scotts Manor Dr. 258				8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		8c. COUNTY OF DEATH Anne Arundel	
9. RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Scotts Manor Dr. 258				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1959 to 1967		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer		15b. KIND OF BUSINESS/INDUSTRY Law Enforcement			
16. FATHER'S NAME (First, Middle, Last) George Francis Suit Jr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Agnes Mexiner			
17a. INFORMANT'S NAME (Type/Print) Barbara Taylor' Suit				17b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 258 Scotts Manor Dr. Glen Burnie, Md. 21061			
18a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		18b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn		18c. DATE April 13		18d. LOCATION — City or Town, State East Point, Md.	
19. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Czajkowski</i>				20. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., Md. 21224			
21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic colon cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>Months</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
22. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				23a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		23b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26d. DESCRIBE NOW INJURY OCCURRED				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
27a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
27b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Gormley M.D.</i>				27c. LICENSE NUMBER D15587		27d. DATE SIGNED (Month, Day, Year) April 11 1995	
28. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Gormley M.D. 900 Caton Ave. Balto., Md. 21229							
29. DATE FILED (Month, Day, Year) APR 12 1995				30. REGISTRAR'S SIGNATURE <i>Julia Anderson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11141

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ronald Shakir</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>10</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>461-72-2232</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 12, 1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Louisiana</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore Veteran Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>	
9c. COUNTY OF DEATH <b>NA</b>				10a. STATE <b>Md</b>			
10b. COUNTY <b>NA</b>				10c. CITY, TOWN OR LOCATION <b>Balto</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2812 Taney Road</b>			
10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Muslim Minister</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Unknown</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Acy Kasaint</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Georgiana</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gajirah Shakin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2812 Taney Rd Balto, Md 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Men Park 4/13/95</b>		20c. LOCATION — City or Town, State <b>Randallstown, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sals March</b>				22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 21215 4300 Wabash Ave Balto, Md</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>liver failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sclerosing cholangitis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>						Approximate Interval Between Onset and Death <b>one week</b> <b>years</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ulcerative colitis</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. H. [Signature]</b>				29c. LICENSE NUMBER <b>P081668</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B.V.A.M.C. 10 S. Greene St, Baltimore, MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11142

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Timothy A. Sweet</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 6 95</b>		3. TIME OF DEATH <b>6:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-80-0618</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>29</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 5, 1965</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>N/A</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>6720 A Edwards Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5440 Addington Rd.</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Correctional Officer State Corrections</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Walter D. Sweet</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virginia M. Samuels</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Walter D. Sweet</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4215 Penhurst Ave. Balto. Md. 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus 4/13/95</b>		20c. LOCATION — City or Town, State <b>Balto. Co. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Primary central nervous system lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Retroniral infection</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>3 weeks</b> <b>2 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Joel E. Gallant, MD</b>				29b. LICENSE NUMBER <b>D38398</b>		29c. DATE SIGNED (Month, Day, Year) <b>4-10-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joel E. Gallant, MD - 600 N. Wolfe St, Carnegie 292, Baltimore, MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Anderson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11143

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Henry SMITH				2. DATE OF DEATH MONTH DAY YEAR April 10 1995		3. TIME OF DEATH 4:58 A M	
4. SOCIAL SECURITY NUMBER 215-12-2286		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 24, 1920	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not Institution, give street and number) FRANKLIN SQUARE		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH Baltimore				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3216 TEXAS AVENUE	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) QUALITY CONTROL		16b. KIND OF BUSINESS/INDUSTRY AERO SPACE	
17. FATHER'S NAME (First, Middle, Last) WILLIAM HENRY SMITH, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA WILLARD			
19a. INFORMANT'S NAME (Type/Print) TODD W. SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216 TEXAS AVE BALTIMORE, MD. 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. LOCATION - City or Town, State 4/13/95 BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Coronary Artery disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes / Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 5 Years 10 Years 30 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorder Hypothyroidism DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Randolph DeCarlo MD</i>				29c. LICENSE NUMBER D44918		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Randolph DeCarlo M.D. 9000 Franklin Square Drive Baltimore, Maryland 21234							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



asp  
95-1949-510

unk 95-092

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-722 4/27/95 t.t

95 11144

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DWAYNE THOMAS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 07 1995</b>		3. TIME OF DEATH HOURS MINUTES AM/PM <b>4:46 A M</b>					
4. SOCIAL SECURITY NUMBER <b>212-70-6841</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 28, 1961</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>1530 W. LEXINGTON ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH <b>N/A</b>				
10a. STATE <b>Md</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5834 Jonquil Avenue</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Unknown</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Aaron Thomas, Jr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Easley</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Eva Thomas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5834 Jonquil Avenue Balto, md 21215</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		DATE <b>41395</b>		20c. LOCATION — City or Town, State <b>Randallstown, Md</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phyllis B. Scott</i>				22. NAME AND ADDRESS OF FACILITY <b>March G/H West</b> <b>4300 Wabash Avenue</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4-7-95 FOUND</b>		28b. TIME OF INJURY <b>4:40 A M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INGESTED DRUGS</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN HOUSE</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1530 W. LEXINGTON ST. BALTIMORE, MD.</b>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne Brethel</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>			29d. DATE SIGNED (Month, Day, Year) <b>APRIL 07, 1995</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Phyllis B. Scott</b> <b>111 N. PENN ST. BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALVIN VALENTINE</b> Alvin M. Valentine, Sr.				2. DATE OF DEATH MONTH 4 DAY 8 YEAR 95		3. TIME OF DEATH 3:00 P M	
4. SOCIAL SECURITY NUMBER 216-12-8205		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-30-14	
9a. FACILITY NAME (If not institution, give street and number) VAMC, FORT HOWARD, MD. 21052				9b. CITY, TOWN OR LOCATION OF DEATH n/a		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1822 Madison Avenue				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical Worker		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corporation			
17. FATHER'S NAME (First, Middle, Last) Lawrence J. Valentine				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Singleton			
19a. INFORMANT'S NAME (Type/Print) Phenola V. Carroll				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1822 Madison Avenue Baltimore, Maryland 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison		20c. LOCATION — City or Town, State Baltimore, Maryland 21216		20d. LOCATION — City or Town, State Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Herbert E. Mitter</i>				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF LIVER DUE TO (OR AS A CONSEQUENCE OF): b. ALCOHOL ABUSE DUE TO (OR AS A CONSEQUENCE OF): c. HEPATIC ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 4578 V		29d. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAUL RIVERA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the funeral director or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and taken to the funeral home to obtain a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5  
10A





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GRACE WASHINGTON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 4, 1995</b>		3. TIME OF DEATH <b>7:30 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>220-24-0481</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 2, 1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1521 Druid Hill Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1521 Druid Hill Avenue</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Thomas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eveline Thomas</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jean Miller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1521 Druid Hill Avenue Baltimore, Maryland 21217</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		DATE <b>Apr 6</b>		20c. LOCATION — City or Town, State <b>Baltimore County, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin Parker</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Cerebral Thrombosis</b>				Approximate Interval Between Onset and Death <b>6 weeks</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Diabetes Mellitus</b>				10 yrs.	
		c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
		d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Bedridden from severe arthritis 2 yrs.</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alan B Cohen</b>				29c. LICENSE NUMBER <b>D 3610</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 5, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan B Cohen 200 E 33rd ST Balt Md 21218</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>John D. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
 BALTIMORE, MARYLAND 21268-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11147

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Wae W. Beck-Williams</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>6</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>10:03 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>173-22-0724A</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>89</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 19, 1906</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Kenswick Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>111 Hamlet Hill Rd.</i>			
10f. ZIP CODE <i>21210</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>X</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>High School Grad</i> College (1-4 or 5+) <i>Educator</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Educator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Baltimore City</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Dr. William H. Wright</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Annie Tyson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Arnett Williams</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>111 Hamlet Hill Rd. Balt. Md. 21210</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park 4/12 Baltimore Maryland</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Herbert E. Nutter</i>				22. NAME AND ADDRESS OF FACILITY <i>Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Balt. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Aspiration pneumonia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Stroke</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the undelying cause given in Part I. <i>Multiple myeloma GI bleeding</i> <i>Anemia Acute leukemia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Isabelle MacGregor MD</i>				29c. LICENSE NUMBER <i>D13657</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 7, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. ISABELLE MACGREGOR, KESWICK, 780 W 40th Street, Baltimore, MD 21211</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12



95-1981-510

B.K.S

95-094

95 11148

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ROBERT LEE WOODS				2. DATE OF DEATH MONTH DAY YEAR APRIL 7 1995				3. TIME OF DEATH 2106 P M							
4. SOCIAL SECURITY NUMBER 213-70-5788		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct 2, 1954		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH Baltimore City					
RESIDENCE OF DECEASED															
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Hanover				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 7090 Ridge Rd.						10f. ZIP CODE 21076		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2 Years				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Technician				16b. KIND OF BUSINESS/INDUSTRY Catonsville Comm. College Computer Center							
17. FATHER'S NAME (First, Middle, Last) John H. Woods						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Earle									
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary C. Woods						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 818 Manchester, MD 21102									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery		DATE 4-12		20c. LOCATION — City or Town, State Pikesville, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John K. Ayres</i>						22. NAME AND ADDRESS OF FACILITY Loring byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 4/7/95		28b. TIME OF INJURY 1730 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED PASSENGER, PLANE CRASH					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FRONT LAWN OF RESIDENCE						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1994 STILL WATER RD. ELDERSBERG MD									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golie Jr MD</i>						29c. LICENSE NUMBER O.C.M.E				29d. DATE SIGNED (Month, Day, Year) APRIL 8, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIE JR MD 111 PENN STREET, BALTIMORE, MARYLAND 21201															
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John H. Woods</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28a marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Harrison David Watson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 8, 1995</b>		3. TIME OF DEATH <b>7:35 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>215-24-9999</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 9, 1929</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Woodlawn</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6610 Richardson Road</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) <b>11th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Optician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Clarke, Appler &amp; Loeber</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harrison David Watson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Kepler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Marilyn R. Watson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6610 Richardson Road Baltimore, Maryland 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. DATE <b>4/12</b>		20d. LOCATION — City or Town, State <b>Woodlawn, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M Jenkins</i>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Hypertensive cerebrovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William J. Chirba</i>				29c. LICENSE NUMBER <b>D29055</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Allen J. Chirba MD 5310 Old Court RD 21133</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


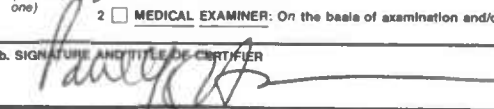
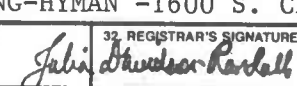
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARLOS AUGUST WHARRY, SR.				2. DATE OF DEATH MONTH DAY YEAR APRIL 7, 1995		3. TIME OF DEATH 0017 M	
4. SOCIAL SECURITY NUMBER 217-20-4568		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 25, 1926	
9a. FACILITY NAME (If not Institution, give street and number) HARBOUR HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION LINTHICUM		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 707 EVELYN AVENUE				10f. ZIP CODE 21090		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced Separated		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CORRECTIONAL OFFICER		16b. KIND OF BUSINESS/INDUSTRY MARYLAND STATE			
17. FATHER'S NAME (First, Middle, Last) WILLIAM F. WHARRY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH B. DEGNER			
19a. INFORMANT'S NAME (Type/Print) FRANCINE YELLOWTHUNDER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 MADINGLEY ROAD - LINTHICUM, MD 21090			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 4/10		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Ischemic Cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER MD-6664		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. PAUL YOUNG-HYMAN -1600 S. CRAIN HIGHWAY - SUITE 601 - GLEN BURNIE, MD							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11151

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>THEODOCIA YOUNG</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>3:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-50-8619</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 1, 1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kentucky</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Charlestown Care Center 711 Maiden Choice Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>711 Maiden Choice Lane Apt#103</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Waddell Lucas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Theodocia Fowles</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Pamela Y. Ash</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9531 Valley Mede Court Ellicott City Maryland 21042</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wylly Cemetery</b>		20c. LOCATION — City or Town, State <b>4/11/95 Waverly, Tennessee</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Leroy M. &amp; Russell C. Witzke Funeral Homes</b> <b>1630 Edmondson Avenue Catonsville, Maryland 21228</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's Dementia</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death <b>year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D26473</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BERNARD F KOZLOVSKY, MD., 711 MAIDEN CHOICE LANE 21228</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

E



95 11152

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BRUNA ZANOBINI</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0435</b> M	
4. SOCIAL SECURITY NUMBER <b>217-33-8705</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 15, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>City</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Stevenson</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10610 Stevenson Road</b>				10f. ZIP CODE <b>21153</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		15b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Julio Zanobini</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Luisa Bandini</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Tulia Briscoe</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10610 Stevenson Road Stevenson, MD 21153</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Charles Cemetery</b>		DATE <b>4/12</b>		20c. LOCATION — City or Town, State <b>Pikesville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James B. Covey</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PULMONARY EMBOLISM</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>PULMONARY EMBOLISM</b> b. <b>INFERIOR VENA CAVA THROMBOSIS</b> c. <b>PNEUMONIA</b> d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>7 Day</b> <b>7 Day</b> <b>2-4 Days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERCOAGULABILITY, HYPERTENSION, S/P IVC FILTER, DIABETES, CORONARY ARTERY DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Eric D. Skolnick MD</b>				29c. LICENSE NUMBER <b>AS-2402321-ES9849</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Eric D. Skolnick SINAI HOSPITAL OF BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia D. Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11153

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Albert F. Zdanis</i>				2. DATE OF DEATH MONTH <i>Apr</i> DAY <i>6</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>4:00P M</i>	
4. SOCIAL SECURITY NUMBER # <i>212 03 9915</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-6-06</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Howard</i>		10c. CITY, TOWN OR LOCATION <i>Lisbon</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1816 Woodbine Road</i>				10f. ZIP CODE <i>21797</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i></i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Tailor/Punch Press</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Sewing/Westinghouse</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Zdanis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <i>Richard Zdanis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2723 Belvoir Blvd, Shaker Hgts, OH 44122</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Site Anatomy Board</i> <i>655W. Baltimore St, Balto, MD 21201</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i> (DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. Approximate Interval Between Onset and Death <i>6 hours</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ventricular aneurysm</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>N/A</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <i>N/A</i>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Beight</i>				29c. LICENSE NUMBER <i>D30928</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 6, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>TWO KNOLL NORTH COLUMBIA, MARYLAND 21045</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

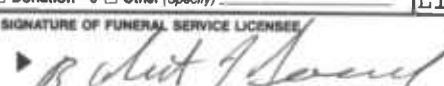
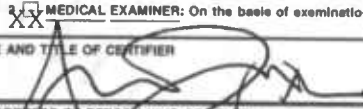

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATSY DARLENE ATWOOD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 02 95</b>		3. TIME OF DEATH <b>12:50 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>195-34-9333</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 4 1942</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>RT.273 &amp; RT.1</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RISING SUN</b>	
9c. COUNTY OF DEATH <b>CECIL COUNTY</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Cecil</b>	
10c. CITY, TOWN OR LOCATION <b>Rising Sun</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>806 Connelly Rd</b>	
10f. ZIP CODE <b>21911</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Mahan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace H. Kauffman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cecil W Atwood</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>806 Connelly Rd Rising Sun MD 21911</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Little Britain Cmty Apr 6 1995</b>			
20c. LOCATION — City or Town, State <b>Pennsylvania</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple injuries</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>4. 2. 95</b>			
28b. TIME OF INJURY <b>0045 M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <b>DRIVER OF VAN. HIT TREE</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Rte 273 &amp; Rte 1. Rising Sun</b>				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>			
29d. DATE SIGNED (Month, Day, Year) <b>APRIL 2, 1995</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET BALTIMORE MARYLAND 21201</b>			
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11155

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES MITCHELL AZARCH</b>						2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 28, 1995</b>		3. TIME OF DEATH <b>6:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>236 22 9111</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 25, 1921</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FERNWOOD HOUSE</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONT.</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MS</b>		10b. COUNTY <b>Forrest</b>		10c. CITY, TOWN OR LOCATION <b>Hattiesburg</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1104 Marie Street</b>				10f. ZIP CODE <b>39401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>8</b>			16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Podiatrist</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Medicine</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Azarch</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine (Unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Weiner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5306 Duvall Dr., Bethesda, MD 20816</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>B'Nai Israel Cem. 3/30</b>		20c. LOCATION — City or Town, State <b>Hattiesburg, MS</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Nelson</i>				22. NAME AND ADDRESS OF FACILITY <b>JOS. GAWLERS SONS INC. 5130 WI AVE N.W. WASHINGTON, D.C. 20016</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>liver failure</i>									
a. DUE TO (OR AS A CONSEQUENCE OF): <i>cirrhosis</i>									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>malnutrition</i>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Blass M.D.</i>				29c. LICENSE NUMBER <b>023911</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 28, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID A. BLASS M.D. 9410 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11156

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HOWARD GILBERT ARMSTRONG, SR.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-28-9829</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 18, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>505 RIDGE RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FINKSBURG</b>	
9c. COUNTY OF DEATH <b>CARROLL</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>CARROLL</b>				10c. CITY, TOWN OR LOCATION <b>FINKSBURG</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>505 RIDGE RD.</b>			
10f. ZIP CODE <b>21048</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
11. MARITAL STATUS <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CONTRACTOR</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HEATING &amp; COOLING</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES WILLIAM ARMSTRONG</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ANNE WILSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY ANN ARMSTRONG</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>505 RIDGE RD., FINKSBURG, MD. 21048</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LAKE VIEW MEM. PARK 3/31</b>		20c. LOCATION — City or Town, State <b>ELDERSBURG, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nancy K. Fletcher</i>	
22. NAME AND ADDRESS OF FACILITY <b>FLETCHER FUNERAL HOME</b> <b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC CARCINOMA OF THE PROSTATE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE</b>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vincent J. Ficco Jr.</i> MD				29c. LICENSE NUMBER <b>DO 1663</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/29/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>VINCENT J. FICCO JR.</b> <b>8 ANCHOR ST</b> <b>WESTMINSTER, MD 21157</b>				31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>			
32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11157

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jessie Fay Ambrose</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:00 P M</b>				
4. SOCIAL SECURITY NUMBER <b>234-07-2589</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/13/12</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Atlantic General hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>		9c. COUNTY OF DEATH <b>Worcester</b>				
RESIDENCE OF DECEDENT										
10a. STATE <b>MD</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Berlin</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>3 Midship Dr.</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Walker D. Snead</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Daisy H. Bridge</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Bettie L. Engel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Midship Dr. Berlin, MD 21811</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salem U.M. Church Cemetery 3/13/95 Gettysburg, PA</b>		20c. LOCATION — City or Town, State						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Burbage Funeral Home 108 Williams St. Berlin, MD 21811</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>COPD</b> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen F. Waters MD</i>				29c. LICENSE NUMBER <b>D27993</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-8-95</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Stephen F. Waters, MD 10th St. &amp; Phila. Ave. Ocean City, MD 21842</b>										
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11158

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA BROWN				2. DATE OF DEATH MONTH 04 DAY 02 YEAR 95		3. TIME OF DEATH 6:50 A M	
4. SOCIAL SECURITY NUMBER 213-20-0164		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 25 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home			
10. CITY, TOWN OR LOCATION OF DEATH Rising Sun				11. COUNTY OF DEATH Cecil			
12. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY Cecil 10c. CITY, TOWN OR LOCATION Rising Sun				13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
14. STREET AND NUMBER 1881 Telegraph Rd				15. ZIP CODE 21911		16. CITIZEN OF WHAT COUNTRY? USA	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: White	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16a. KIND OF BUSINESS/INDUSTRY Nursing Home					
17. FATHER'S NAME (First, Middle, Last) Chester Gregg				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Ramsey			
19a. INFORMANT'S NAME (Type/Print) Mary Crothers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Long Green Farm Rising Sun MD 21911			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rosebank Cmty Apr 5 1995		20c. LOCATION — City or Town, State Calvert MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Joogie</i>				22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911			
23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Carcinoma of Breast Metastases</i> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <i>2 yrs</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul R Taylor MD</i>		29c. LICENSE NUMBER ①-1115		29d. DATE SIGNED (Month, Day, Year) 4-02-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Neil Taylor MD Rising Sun, MD 21911							
31. DATE FILED (Month, Day, Year) APR 03 1995				32. REGISTRAR'S SIGNATURE <i>Julia M. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11159

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY A. BARKULOO				2. DATE OF DEATH MONTH DAY YEAR 04 02 95		3. TIME OF DEATH 1:05 P M	
4. SOCIAL SECURITY NUMBER 220-22-4666		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 24 1902	
9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1881 Telegraph Rd				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Alvin B. Nickle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie R. Fisher			
19a. INFORMANT'S NAME (Type/Print) Bill Barkuloo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6612 Blackhead Rd Baltimore MD 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) West Nottingham Cmty Apr 6 1995		20c. LOCATION — City or Town, State Colora Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>A.S.C.V.D.</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Advanced age</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 5 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER 011115		29d. DATE SIGNED (Month, Day, Year) 4-3-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bill Taylor Rising Sun, MD 21911							
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE APR 03 1995					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly includes a diagram or table in the upper right quadrant.]*

95 11160

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN EDITH BENDL</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:58 P M</b>	
4. SOCIAL SECURITY NUMBER <b>184-16-2185</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 23, 1922</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		8c. COUNTY OF DEATH <b>Montgomery</b>	
9a. STATE <b>Maryland</b>		9b. COUNTY <b>Montgomery</b>		9c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>12013 Cheyenne Road</b>				10b. ZIP CODE <b>20878</b>		10c. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bank Teller</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert S. Buchanan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Bowman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anthony Bendl</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12013 Cheyenne Road Gaithersburg, Maryland 20878</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>March 30, 1995</b>		20c. LOCATION — City or Town, State <b>Derry, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Delman &amp; Sato</b> M00202				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. EMPHYSEMA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. SMOKING</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Approximate Interval Between Onset and Death <b>6 MOS</b> <b>YRS</b> <b>YRS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIP FRACTURE, OVARIAN TUMORS, OSTEOPOROSIS, DEPRESSION</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Steven T. Kariya MD</b>				29c. LICENSE NUMBER <b>236252</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>STEVEN T. KARIYA, MD, 16220 FREDERICK RD, GAITHERSBURG MD 20877</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TOBIN J. BRUENING</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 28, 1995</b>		3. TIME OF DEATH <b>5:22 A M</b>					
4. SOCIAL SECURITY NUMBER <b>278-78-3481</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>20 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 14, 1975</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>18855 BENT WILLOW CIRCLE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GERMANTOWN</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>Ohio</b>		10b. COUNTY <b>Cuyahoga</b>		10c. CITY, TOWN OR LOCATION <b>Lakewood</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1327 Bonnieview Ave.</b>				10f. ZIP CODE <b>44187</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Feb. 94 - Active Duty</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Defense</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Navy</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Thomas E. Bruening</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara E. Adams</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Barbara E. Adams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1327 Bonnieview Ave. Lakewood, Ohio 44187</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		DATE <b>4/3</b>		20c. LOCATION — City or Town, State <b>Brookpark, Ohio</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas S. Chambers # 670</b>				22. NAME AND ADDRESS OF FACILITY <b>W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. INTRACRANIAL GUNSHOT WOUND</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>3 28 95</b>		28b. TIME OF INJURY <b>Δ M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT SELF</b>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>18855 Bent Willow Circle, Montgomery</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David A. Bell</b>						29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 29, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYANN A. KORSEY 111 PENN STREET BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>											

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1.  $\frac{1}{x} = x^{-1}$

2.

3.  $\frac{1}{x^2} = x^{-2}$

4.  $\frac{1}{x^3} = x^{-3}$

5.  $\frac{1}{x^4} = x^{-4}$

6.  $\frac{1}{x^5} = x^{-5}$

7.  $\frac{1}{x^6} = x^{-6}$

8.  $\frac{1}{x^7} = x^{-7}$

9.  $\frac{1}{x^8} = x^{-8}$

10.  $\frac{1}{x^9} = x^{-9}$

11.  $\frac{1}{x^{10}} = x^{-10}$

12.  $\frac{1}{x^{11}} = x^{-11}$

13.  $\frac{1}{x^{12}} = x^{-12}$

14.  $\frac{1}{x^{13}} = x^{-13}$

15.  $\frac{1}{x^{14}} = x^{-14}$

16.  $\frac{1}{x^{15}} = x^{-15}$

17.  $\frac{1}{x^{16}} = x^{-16}$

18.  $\frac{1}{x^{17}} = x^{-17}$

19.  $\frac{1}{x^{18}} = x^{-18}$

20.  $\frac{1}{x^{19}} = x^{-19}$

21.  $\frac{1}{x^{20}} = x^{-20}$

22.  $\frac{1}{x^{21}} = x^{-21}$

23.  $\frac{1}{x^{22}} = x^{-22}$

24.  $\frac{1}{x^{23}} = x^{-23}$

25.  $\frac{1}{x^{24}} = x^{-24}$

26.  $\frac{1}{x^{25}} = x^{-25}$

27.  $\frac{1}{x^{26}} = x^{-26}$

28.  $\frac{1}{x^{27}} = x^{-27}$

29.  $\frac{1}{x^{28}} = x^{-28}$

30.  $\frac{1}{x^{29}} = x^{-29}$

31.  $\frac{1}{x^{30}} = x^{-30}$

32.  $\frac{1}{x^{31}} = x^{-31}$

33.  $\frac{1}{x^{32}} = x^{-32}$

34.  $\frac{1}{x^{33}} = x^{-33}$

35.  $\frac{1}{x^{34}} = x^{-34}$

36.  $\frac{1}{x^{35}} = x^{-35}$

37.  $\frac{1}{x^{36}} = x^{-36}$

38.  $\frac{1}{x^{37}} = x^{-37}$

39.  $\frac{1}{x^{38}} = x^{-38}$

40.  $\frac{1}{x^{39}} = x^{-39}$

41.  $\frac{1}{x^{40}} = x^{-40}$

42.  $\frac{1}{x^{41}} = x^{-41}$

43.  $\frac{1}{x^{42}} = x^{-42}$

44.  $\frac{1}{x^{43}} = x^{-43}$

45.  $\frac{1}{x^{44}} = x^{-44}$

46.  $\frac{1}{x^{45}} = x^{-45}$

47.  $\frac{1}{x^{46}} = x^{-46}$

48.  $\frac{1}{x^{47}} = x^{-47}$

49.  $\frac{1}{x^{48}} = x^{-48}$

50.  $\frac{1}{x^{49}} = x^{-49}$

51.  $\frac{1}{x^{50}} = x^{-50}$



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) WILLIAM MICHAEL BURLINGAME				2. DATE OF DEATH MONTH DAY YEAR 03 23 1995		3. TIME OF DEATH 12:40P M					
4. SOCIAL SECURITY NUMBER 215-78-7529		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 28, 1959		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LANHAM			9c. COUNTY OF DEATH PRINCE GEORGES				
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 8803 62nd Avenue				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Data Processing Manager			16b. KIND OF BUSINESS/INDUSTRY Computer						
17. FATHER'S NAME (First, Middle, Last) William Hayden Burlingame				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Marie Lowey							
19a. INFORMANT'S NAME (Type/Print) Doris M. Burlingame				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 Calvert St., Hyattsville, MD 20783							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft Lincoln Cemetery 03-27-95		20c. LOCATION — City or Town, State Brentwood, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Head Injuries</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 3/23/95		28b. TIME OF INJURY 1203 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Driver in auto accident			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Kuplan STREET					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) March 24, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 27 1995						32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


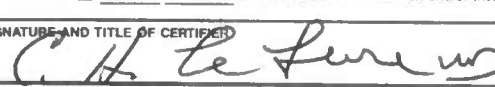
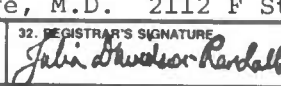
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11163

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jane McKenzie Beecham				2. DATE OF DEATH MONTH DAY YEAR March 25, 1995		3. TIME OF DEATH 6:30 am M	
4. SOCIAL SECURITY NUMBER 550-36-4154		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 20, 1923	
8. BIRTHPLACE (State or Foreign Country) California				9a. FACILITY NAME (If not institution, give street and number) 7304 Western Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Chevy Chase				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7304 Western Avenue	
10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Potter		16b. KIND OF BUSINESS/INDUSTRY Self Employed	
17. FATHER'S NAME (First, Middle, Last) Edward McKenzie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Harscha			
19a. INFORMANT'S NAME (Type/Print) Charles R. Beecham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 Western Avenue Chevy Chase, Maryland 20815			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) March 26, 1995 Montgomery Crematorium Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Adenocarcinoma of Colon</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 3 Years							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DC 10731		29d. DATE SIGNED (Month, Day, Year) March 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christian H. LeFevre, M.D. 2112 F Street, N.W., Washington, DC 20037							
31. DATE FILED (Month, Day, Year) MAR 27 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11164

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AMEL M. BROYLES</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>519-12-7293</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 27, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CARRIAGE HILL - BETHESDA</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>P.O. Box 633</b>		10f. ZIP CODE <b>20848</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 yrs</b> College (1-4 or 5+) <b>Accountant</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Joseph E. Broyles</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary P. Oliver</b>				19a. INFORMANT'S NAME (Type/Print) <b>Marva J. Kelley (Niece)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1108 Parrish Dr., Rockville, MD 20851</b>	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 3/29 Alexandria, VA</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Pyelonephritis</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sidney J. Cohen</i>		29c. LICENSE NUMBER <b>D01193</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3/28/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sidney J. Cohen, M.D. 121 Congressional Lane, Rockville, MD 20852</b>		31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>	
32. REGISTRAR'S SIGNATURE <i>Jahia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11165

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BRENDA BRYANT</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>21</b> YEAR <b>1995</b> 7 <sup>10</sup> <sub>p.m.</sub>		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 9, 1955</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4051 Chesterwppd Drive</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charlie Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mable Pinkney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mable P. Wilson (Mother)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9213 Columbia Blvd., Silver Spring, MD 20910</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 3/29</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Immune Thrombocytopenia</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death <b>12 hours</b> <b>6 weeks</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth Miller MD</i>				29c. LICENSE NUMBER <b>D 33 686</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/21/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kenneth Miller, MD</b>				31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>			
32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>				33. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11166

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David Best, Sr.</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>21</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>4:01 A M</i>	
4. SOCIAL SECURITY NUMBER <i>237-74-6667</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>47</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>April 16, 1947</i>	
8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Prince George's Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Cheverly</i>	
9c. COUNTY OF DEATH <i>Prince George's</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>	
10c. CITY, TOWN OR LOCATION <i>Riverdale</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>6025 - 67th Avenue</i>	
10f. ZIP CODE <i>20737</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Police Officer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Law Enforcement</i>			
17. FATHER'S NAME (First, Middle, Last) <i>George Allen Williams</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah Elizabeth Best</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Annie Rice (Sister)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 S. Round St, New Castle, PA 16101</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Castle View Memorial Gardens 3/29</i>			
20c. LOCATION — City or Town, State <i>Neshannock Twp, PA</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00827			
22. NAME AND ADDRESS OF FACILITY <i>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Angiopathy</i>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>D21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 23, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cp Spr. Md 20748</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 29 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Swickard-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11167

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Harriet B. Busby</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 26 1995</b>		3. TIME OF DEATH <b>3:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578-40-9229</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 20, 1906</b>	
8. FACILITY NAME (If not institution, give street and number) <b>17305 New Hampshire Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10820 Georgia Ave Apt. #305</b>			
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Bernard Favian Joy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriet P. Ward</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernard Busby</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17305 New Hampshire Ave. Silver Spring, Md. 20905</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem. 3/29/95 Silver Spring, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley D. Rinaldi</i>				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave. Silver Spring, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>cardiovascular collapse</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>cardiac arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>arteriosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute respiratory infection</b> <b>diabetes mellitus non insulin dep.</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph M. Solinas MD</i>				29c. LICENSE NUMBER <b>810101</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH M. SOLINAS, MD - 9801 GEORGIA AVE. - SILVER SPRING - Md 20902</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11168

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAIR WILLARD BRYAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 30, 1995</b>		3. TIME OF DEATH <b>8 39 P M</b>	
4. SOCIAL SECURITY NUMBER <b>170-12-5538</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 15, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>	
10e. STREET AND NUMBER <b>805 Maxa Rd.</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>3 X Widowed 2 Married 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Proof Director</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jesse Earl Bryant</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elsie Margaret Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Randall D. Bryant</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1503 Van Bibber Rd., Edgewood, Md. 21040</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Huntingdon Mem. Gardens 4-3-95</b>		20c. LOCATION — City or Town, State <b>Huntingdon, Pa.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Stephen A. Huggs</b>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard J. Colfer MD MEDICAL EXAMINER</b>				29c. LICENSE NUMBER <b>00ME</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RICHARD J. COLFER, MD</b>				31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>			
				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

X  
Richard G. Gifford  
JUL 28, 1962

95 11169

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Arthur Lee Binger, Sr.				2. DATE OF DEATH MONTH DAY YEAR March 29, 1995		3. TIME OF DEATH 3:30 A M	
4. SOCIAL SECURITY NUMBER 578-01-6906		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 3, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Clinton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8625 Dangerfield Place				10f. ZIP CODE 20735		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mill Self-Employed		16b. KIND OF BUSINESS/INDUSTRY Feed and Grain			
17. FATHER'S NAME (First, Middle, Last) James Edward Binger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lorena Smith			
19a. INFORMANT'S NAME (Type/Print) Martha Wood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8625 Dangerfield Place, Clinton, Md 20735			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cem. March 31, 1995		20c. LOCATION — City or Town, State Suitland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RUPTURED ABDOMINAL VISCUS DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D18545		29d. DATE SIGNED (Month, Day, Year) MARCH 29, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Phillip Wisotsky MD 6188 Oxon Hill Rd # 601 Oxon Hill, Md 20745-3113							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11170

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Floyd Warren Bookhultz				2. DATE OF DEATH MONTH DAY YEAR March 28, 1995		3. TIME OF DEATH 16:00	
4. SOCIAL SECURITY NUMBER 578-16-6121		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 15, 1921	
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince, Frederick		9c. COUNTY OF DEATH Calvert	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Dunkirk		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9700 Tara Drive				10f. ZIP CODE 20754		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber		16b. KIND OF BUSINESS/INDUSTRY Commercial Industry			
17. FATHER'S NAME (First, Middle, Last) John Milford Bookhultz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Claudia Owens			
19a. INFORMANT'S NAME (Type/Print) Richard Bookhultz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 Starlight Court, Huntingtown, MD 20639			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cem, March 31, 1995		20c. LOCATION — City or Town, State Suitland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Squamous cell carcinoma since</i>					
		b. <i>At Lung with</i>					
		c. <i>metastasis</i>					
		d. <i>Cholesteria</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>C.H.B. &amp; M.C.V.D.</i> <i>Arteriosclerosis &amp; P.V. D.T.</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. P. Shah M.D.</i>				29c. LICENSE NUMBER D-22634		29d. DATE SIGNED (Month, Day, Year) 3/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Mahesh Shah Prince Frederick MD.							
31. DATE FILED (Month, Day, Year) APR 04 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11171

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THELMA V. BORRELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 31 1995</b>		3. TIME OF DEATH <b>6:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-62-1741</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 17, 1906</b>	
8. FACILITY NAME (If not institution, give street and number) <b>SOUTHEAST Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>9607 Wagner Tr.</b>			
10f. ZIP CODE <b>20735</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert H. Owens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Marr</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Borrell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9607 Wagner Tr. Clinton, Md 20735</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery April 3, 1995 Suitland, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Arrhythmia</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>Hypertension</b> c. <b>Cerebrovascular accident</b> d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> e. <b>6 Months</b> f. <b>12 Months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D-24535</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Laxmi BEAWA 7700 OLD BRANCH AVENUE CLINTON MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11172

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vivian Jacqueline Becker				2. DATE OF DEATH MONTH DAY YEAR April 2, 1995		3. TIME OF DEATH 6:37 P M	
4. SOCIAL SECURITY NUMBER 578-12-3226		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul 29, 1921	
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn		9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Mechanicsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2 Marshall Road				10f. ZIP CODE 20659		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Retail Department Store			
17. FATHER'S NAME (First, Middle, Last) Wilfurd Southworth				16. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Kephart			
19a. INFORMANT'S NAME (Type/Print) Milton L. Becker, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marshall Road, Mechanicsville, MD 20659			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Memorial Park		DATE 4-6		20c. LOCATION — City or Town, State Falls Church, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark G. Brohawn M00053				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Umed K. Shah		29c. LICENSE NUMBER D15369		29d. DATE SIGNED (Month, Day, Year) 4/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Umed K. Shah, Shanti Medical Center, Box 664, Leonardtown, MD 20650							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11173

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marie Boyd Brown</b>			2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 20 1995</b>		3. TIME OF DEATH <b>2105 PM</b>	
4. SOCIAL SECURITY NUMBER <b>182-26-4432-A</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>72</b> YRS.	7. DATE OF BIRTH MONTH DAY YEAR <b>February 12, 1923</b>	8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Wicomico</b>	10c. CITY, TOWN OR LOCATION <b>Mardela</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1104 Norris Twilley Road</b>			10f. ZIP CODE <b>21837</b>	10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Byers</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearlee Withers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Byard Brown</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1104 Norris Twilley Road - Mardela, MD 21837</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion U. M. Church Cemetery 3/27</b>		20c. LOCATION — City or Town, State <b>Sharptown, MD</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell L. Fooks</i>			22. NAME AND ADDRESS OF FACILITY <b>Fooks Funeral Service 917 W. Isabella Street - Salisbury, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRAIN DEATH</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div>           b. <b>SUBARACHNOID HEMORRAGE</b>            c. <b>UPPER GI</b>            d. <b>DIABETES</b> </div> </div>					Approximate Interval Between Onset and Death <b>3/20/95</b> <b>3/10/95</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. D. [Signature] MD</i>		29c. LICENSE NUMBER <b>D19432</b>	29d. DATE SIGNED (Month, Day, Year) <b>3/20/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1560 [Address] In A102 Salisbury, MD 21801</b>						
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>				

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





ITEMS : 23 PART I, 27 PER MEOG-722 4/21/95reb

95 11174

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NICHOLAS HOWARD BRACKINS				2. DATE OF DEATH MONTH DAY YEAR MARCH 29 1995		3. TIME OF DEATH 6:50 A.M.					
4. SOCIAL SECURITY NUMBER 217-43-4458		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 1 19		7. DATE OF BIRTH (Month, Day, Year) Feb 10, 1995		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 3970 TEN OAKS ROAD				9b. CITY, TOWN OR LOCATION OF DEATH CLARKSVILLE			9c. COUNTY OF DEATH HOWARD				
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Dayton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5236 Greenbridge				10f. ZIP CODE 21036		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A							
17. FATHER'S NAME (First, Middle, Last) Christopher L. Brackins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Penny L. Tetlow							
19a. INFORMANT'S NAME (Type/Print) Penny & Chris Brackins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5236 Greenbridge Dayton, Maryland 21036							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Linthicum Chapel Cemetery Apr 1		20c. LOCATION — City or Town, State Clarksville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stanley M. Lowner				22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City 21043							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER DARON LOCKE MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MARCH 30, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DARON LOCKE MD 111 PENN STREET, BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE Julia Shivers Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11175

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Julie L. Cheng</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 18, 1995</b>		3. TIME OF DEATH <b>11 PM</b>	
4. SOCIAL SECURITY NUMBER <b>229-90-7161</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 20, 1947</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Taiwan</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Potomac</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7308 Loch Eden Court</b>	
10f. ZIP CODE <b>20854</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Asian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Computer Analyst</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Gi Muh Chu</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>A-Yu Chu</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Long Cheng</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7308 Loch Eden Ct Potomac MD 20854</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Northern Va. Crematory 3/23/95</b>		20c. LOCATION — City or Town, State <b>Arlington, Va. 22203</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Arlington Funeral Home</b> <b>3901 No. Fairfax Dr. -Arl., VA 22203</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC CARCINOMA OF UNKNOWN ORIGIN</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>INTRACRANIAL BLEEDING.</b> c. d. Approximate Interval Between Onset and Death <b>8 months</b> <b>1 DAY</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>THROMBOCYTOPENIA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 33224</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 19, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. T. TROTTER 50W Edmonston Dr #401, ROCKVILLE Md 20852</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


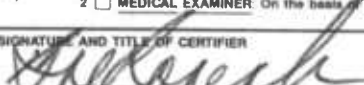
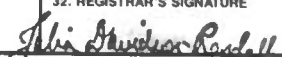
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11176

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ching Lan Chu</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>26</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>9:30 A M</b>		
4. SOCIAL SECURITY NUMBER <b>212-08-7787</b>		5. SEX <b>1 M 2 F</b>	8. AGE (In yrs. last birthday) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS <b>73</b> DAYS <b>73</b>	IF UNDER 24 HRS. HOURS <b>73</b> MIN. <b>73</b>	7. DATE OF BIRTH (Month, Day, Year) <b>February 24, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>China</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Circle Manor Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Kensington</b>			9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Germantown</b>			10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>11532 Doxdam Terrace</b>				10f. ZIP CODE <b>20876</b>			10g. CITIZEN OF WHAT COUNTRY? <b>China</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Oriental</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jin Fu Chu</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Shui Jin Li</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Jian Cheung Au</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11532 Doxdam Terrace Germantown, Maryland 20876</b>						
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/1/95</b>			20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung with Metastases to Brain</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Approximate Interval Between Onset and Death: 1 year</b>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>										
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>										
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>								
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE NOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 09834</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, Maryland 20895</b>										
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11177

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Malcolm E. Cox				2. DATE OF DEATH MONTH DAY YEAR March 21 1995		3. TIME OF DEATH 4:15 P.M.	
4. SOCIAL SECURITY NUMBER 220-05-7335		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 29, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11500 Nairn Road	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 - 1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Electrical Union	
17. FATHER'S NAME (First, Middle, Last) James T. Cox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Peach			
19a. INFORMANT'S NAME (Type/Print) Nina F. Cox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11500 Nairn Road, Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 3/28		20c. LOCATION — City or Town, State Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louis Trent-Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Valve Replacement Atrial fibrillation							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank N. Grayino, MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank N. Grayino, 10313 Georgia Ave, Suite 307, Silver Spring, MD 20902							
31. DATE FILED (Month, Day, Year) MAR 27 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





4/17/95  
amended cert #4, Harford County, S.B.

95 11178

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Hector Antonio Cannistra</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:50 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>050-10-7807</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>31</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 17, 1963</b>		8. BIRTHPLACE (State or Foreign Country) <b>Argentina</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>			9c. COUNTY OF DEATH <b>Harford</b>				
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Edgewood</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>400 Regina Drive</b>				10f. ZIP CODE <b>21040</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ambulance Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Ambulance Service</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Antonio (nm) Cannistra</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carolina Hilda D'ambrosio</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Josephine Cannistra</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Regina Drive, Edgewood, Md. 21040</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cem. 3-31-95 Baltimore, Md.</b>		20c. LOCATION — City or Town, State		20d. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Stephen A. Hughes</b>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Adult Respiratory Distress Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Morbid obesity</b> DUE TO (OR AS A CONSEQUENCE OF): <b></b>								Approximate Interval Between Onset and Death <b>6 Hours</b> <b>12 Hours</b> <b>8 years</b>			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Cardiomyopathy</b> <b>Pulmonary Embolism</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. LICENSE NUMBER <b>H38022</b>		29c. DATE SIGNED (Month, Day, Year) <b>March 29 1995</b>					
29d. SIGNATURE AND TITLE OF CERTIFIER <b>Peter J. Lopresti, M.D.</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER J. LOPRESTI, M.D. 1308 Business City Way Edgewood MD 21040</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jane Brundage Hardell</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11179

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Doris Marion Coakley</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10A</b> M	
4. SOCIAL SECURITY NUMBER <b>219-12-8515</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-27-1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>214 Market Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>214 Market Street</b>				10f. ZIP CODE <b>21078</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Utility Co. (Telephone)</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Mergler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Marion Stone</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Ann M. Todd</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>213 N. Union Avenue, Havre de Grace, MD 21078</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>		DATE <b>3/31</b>		20c. LOCATION — City or Town, State <b>Havre de Grace, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William S. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>① Cardiac arrest, probably</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Ante Myocardial infarction</b> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>+ Cardiac arrhythmia</b> <b>③ HASCUP</b> DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Yun M.D.</i>				29c. LICENSE NUMBER <b>D12190</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John D. Yun, M.D., 319 S. Union Avenue, Havre de Grace, MD 21078 (339-4477)</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>Philip Ciotti</u> PHILIP CIOTTI				2. DATE OF DEATH MONTH <u>4</u> - DAY <u>2</u> - YEAR <u>1995</u>		3. TIME OF DEATH <u>4:15 p.m.</u>			
4. SOCIAL SECURITY NUMBER <u>210-03-0258</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Feb. 26, 1917</u>		8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>CITIZENS NURSING HOME</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>HAVRE DE GRACE MD</u>			9c. COUNTY OF DEATH <u>HARFORD</u>		
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Havre de Grace</u>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <u>844 Locust Lane</u>				10f. ZIP CODE <u>21078</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Commercial Designer</u>			16b. KIND OF BUSINESS/INDUSTRY <u>Federal Government</u>		
17. FATHER'S NAME (First, Middle, Last) <u>Nunzio Ciotti</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Giacomina Antonacci Ciotti</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Charlotte Barker</u>				19b. <u>101</u> ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>101 McSpadden Drive, Havre de Grace, MD 21078</u>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Richland Cemetery</u>		DATE <u>3/8</u>		20c. LOCATION — City or Town, State <u>Windber, PA</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Madelyn Mitchell Shantz</u>				22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardio Pulmonary Arrest</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <u>ATHEROSCLEROSIS</u> <u>Arteriosclerosis</u>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerosis</u> <u>Arteriosclerosis</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29a. SIGNATURE AND TITLE OF CERTIFIER <u>T. Brando MD</u>				29c. LICENSE NUMBER <u>042800</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/2/95</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>T. Brando MD, UMC 3145 Calver Ave, HLG, Md., 21078</u>									
31. DATE FILED (Month, Day, Year) <u>APR 04 1995</u>		32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>							



Amended item #7, 9/28/95, Harford County, S.O. 95 11181

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Walter Ruley Coakley</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>26</b> YEAR <b>95</b>		3. TIME OF DEATH <b>7:35A</b> M	
4. SOCIAL SECURITY NUMBER <b>218-03-8091</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-26-1895</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. FACILITY NAME (If not institution, give street and number) <b>424 Market Street</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace</b>				11. COUNTY OF DEATH <b>Harford</b>			
12a. STATE <b>MD</b>		12b. COUNTY <b>Harford</b>		12c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>		12d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
13. STREET AND NO NUMBER <b>424 Market Street</b>				14. ZIP CODE <b>21078</b>		15. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW I</b>		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>College</b>		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plumber</b>		22. KIND OF BUSINESS/INDUSTRY <b>Veterans Hospital</b>			
23. FATHER'S NAME (First, Middle, Last) <b>Eugene W. Coakley</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Gilbert</b>			
25. INFORMANT'S NAME (Type/Print) <b>Mr. Walter Basil Coakley</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>422 Market Street, Havre de Grace, MD 21078</b>			
27. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>		29. DATE <b>3/30</b>		30. LOCATION — City or Town, State <b>Havre de Grace, MD</b>	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE 				32. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CACHEXIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>METASTATIC LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>CARCINOMA LUNG.</b> DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY <b>M</b>		38. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				40. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
41. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
42. SIGNATURE AND TITLE OF CERTIFIER 				43. LICENSE NUMBER <b>D21809</b>		44. DATE SIGNED (Month, Day, Year) <b>3-26-95</b>	
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GANEH S. PRABHU MD 1810 BELAIR RD #102 FALLS CH MD 21047</b>							
46. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11182

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILTON Maurice CRUMP				2. DATE OF DEATH MONTH DAY YEAR APRIL 3, 1995		3. TIME OF DEATH 1 50A M	
4. SOCIAL SECURITY NUMBER 579-03-8629		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 27, 1917	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 15640 St Thomas Church Road				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Production Management Spec Dept U.S. Navy		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Owen E. Crump				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cynthia Alsopp			
19a. INFORMANT'S NAME (Type/Print) Neva J. Crump				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15640 St Thomas Church Road, Upper Marlboro, Md 20772			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St Thomas Episcopal Cem April 6, 1995		20c. LOCATION — City or Town, State Croom, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary heart disease</u> <u>Cerebrovascular disease</u> <u>Diabetes</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>David M. Goldman MD</u>				29c. LICENSE NUMBER D04374		29d. DATE SIGNED (Month, Day, Year) April 3, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Goldman 7500 Hanover Pkwy, #105 Greenbelt, Maryland 20770							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE <u>John A. Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11183

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Susan Marie Devers</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 30, 1995</b>				3. TIME OF DEATH <b>12:45 P.</b>	
4. SOCIAL SECURITY NUMBER <b>214-60-6462</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>41</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 3, 1954</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>24 Fenceline Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>			9c. COUNTY OF DEATH <b>Montgomery</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>24 Fenceline Drive</b>				10f. ZIP CODE <b>20878</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Edward Joseph Devers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne Teresa Swanberry</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Kathy A. Cordelli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13216 Trimfield Lane, Germantown, Maryland 20874</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		DATE <b>3/31</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr., Gaithersburg, MD 20877</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>A.I.D.S.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HIV</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death <b>3 days</b> <b>18 months</b> <b>8 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>possible herpes retinitis (3 months) not CMV,</b> <b>refractory anal herpes. Seizures</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D20097</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 31, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Susan Williams, M.D. 2000 Dennis Avenue, Silver Spring, Maryland 20902</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11184

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY V D'ANDREA</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>26</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>193-05-6088</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 14, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Beltsville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>11811 North Lincoln Avenue</b>	
10f. ZIP CODE <b>20705</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>housewife</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>private</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Anthony DeStefano</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Peschio</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alvin Joseph D'Andrea (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery March 30, 1995</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>SEVERE BILATERAL PNEUMONIA</b>							
b. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b>							
c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>							
d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>S/P AORTIC / MITRAL VALVE REPLACEMENT ; BYPASS</b> <b>SURGERY ; POLYMYALGIA RHEUMATICA ; CHOLESTEROL</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christine De Lima MD</i>				29c. LICENSE NUMBER <b>D 22755</b>		29d. DATE SIGNED (Month, Day, Year) <b>3. 27. 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHRISTINE DELIMA MD 7350 VAN DUSEN RD #260 LAUREL MD 20677</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11185

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roland J. Donaldson, Jr.				2. DATE OF DEATH MONTH DAY YEAR March 26, 1995		3. TIME OF DEATH 1:05 P M	
4. SOCIAL SECURITY NUMBER 220-40-6126		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 26, 1942	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3910 Lantern Drive	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1961-1966				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Printing	
17. FATHER'S NAME (First, Middle, Last) Roland J. Donaldson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Ione Coffey			
19a. INFORMANT'S NAME (Type/Print) William C. Donaldson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11024 Fawsett Road, Potomac, MD 20854			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. LOCATION — City or Town, State 3-27 Beltsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eileen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated histoplasmosis DUE TO (OR AS A CONSEQUENCE OF): b. acquired immune deficiency syndrome DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 1 month 9 months							Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancytopenia Renal failure hepatic failure hypernatremia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lynette H. Pasorske MD				29c. LICENSE NUMBER D43228		29d. DATE SIGNED (Month, Day, Year) 3/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lynette H. Pasorske MD 8630 Fenton St #230 Silver Spring MD 20910							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE John A. Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11186

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>25</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>1:35 PM</b>	
4. SOCIAL SECURITY NUMBER <b>579-28-8246</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 16, 1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ireland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9306 Cedar Lane</b>				10f. ZIP CODE <b>20814</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Owen Muckian</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bridget</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mary O'Donoghue Homa</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2909 Edgewater Drive Edgewater, Maryland 21037</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 3/28/95</b>				20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>arteriosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>today</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Generalized arteriosclerosis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>William H. Efronmontant M.D.</b>		29c. LICENSE NUMBER <b>D00946 ML</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/26/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wilfred Russell Efronmontant M.D. 11125 Rockville Pike Rockville MD 20852</b>								31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>	
32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11187

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Winifred E. Denio</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 26, 1995</b>		3. TIME OF DEATH <b>0140 A M</b>	
4. SOCIAL SECURITY NUMBER <b>146-20-3101</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 28, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>England</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Westminster Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminister</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Westminister</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1234 Washington Road</b>	
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Lepley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Hatton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy M. Lange</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Park View Ter., Westminister, MD 21157</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cemetery</b>		20c. LOCATION — City or Town, State <b>3/30 Somerville, NJ</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael G. Melson</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. NW, Washington, DC 20016</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardio-Cerebral Vascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel I. Welliver M.D.</i>				29c. LICENSE NUMBER <b>D11496</b>		29d. DATE SIGNED (Month, Day, Year) <b>Mar. 26, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel I. Welliver, MD, 912 Washington Rd., Westminister, MD 21157</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Carroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11188

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DORRIEA</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>30</b> , 1995 YEAR				3. TIME OF DEATH <b>3:43 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-0887</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 7, 1910</b>				8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not Institution, give street and number) <b>PHYSICIAN MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LA PLATA</b>				9c. COUNTY OF DEATH <b>CHARLES</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CHARLES</b>		10c. CITY, TOWN OR LOCATION <b>LA PLATA</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>#10747 LA PLATA ROAD</b>				10f. ZIP CODE <b>20646</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>4TH GRADE</b> College (1-4 or 5+) <b></b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>		15b. KIND OF BUSINESS/INDUSTRY <b>HEALTH INDUSTRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LEMUEL DODSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CORA ELIZABETH CHUNG DODSON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>LEMUEL HEARD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE #1 BOX #405A NANJEMOY, MARYLAND 20662</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ZION BAPTIST CHURCH CEM. 4/4/95</b>		DATE <b>4/4/95</b>		20c. LOCATION — City or Town, State <b>WELCOME, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lidia C. Thornton Johnson</i> <b>LIDIA C. THORNTON JOHNSON MO0583</b>				22. NAME AND ADDRESS OF FACILITY <b>THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Chronic obstructive pulmonary disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>atherosclerosis per se cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-22574</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. Timothy Pace, M.D. Waldorf Medical Park Waldorf, Maryland 20604</b>									
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11189

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Goldie Marie Donahue</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>909 a</b> M	
4. SOCIAL SECURITY NUMBER <b>577-14-0042</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 13, 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7510 Kipling Parkway</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>District Heights</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>District Heights</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7510 Kipling Parkway</b>				10f. ZIP CODE <b>20747</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Russell Mundy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Brawner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Julia Bilodeau</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1428 Alberta Drive, Forestville, Md 20747</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Resurrection Cemetery 3-30-95</b>		20c. LOCATION — City or Town, State <b>Clinton, Md</b>		20d. LOCATION — City or Town, State <b>Clinton, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road, Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>10 yrs +</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D10 272-M.A</b>		29d. DATE SIGNED (Month, Day, Year) <b>3. 27. 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Sheer 6400 Marlboro Pike, District Heights, Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11190

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Wilson Monroe Dashiell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar. 20, 1995</b>		3. TIME OF DEATH <b>12:33 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-22-8525</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 12, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7988 Levin Dashiell Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hebron</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Hebron</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7988 Levin Dashiell Road</b>	
10f. ZIP CODE <b>21830</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Dashiell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Stella Winder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Brenda Clark</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5795 Cairn Ct. Salisbury, Md. 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Mem. Gardens 4/27</b>		20c. LOCATION — City or Town, State <b>Hebron, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys B. Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer Prostate</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate interval Between Onset and Death <b>3 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D34976</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/23/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>106 Pine Bluff Rd. Salisbury, md 21801</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 23 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11191

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ralph hazel eveland sr.				2. DATE OF DEATH MONTH DAY YEAR mar 27 1995		3. TIME OF DEATH 1711 M	
4. SOCIAL SECURITY NUMBER 213 10 9759		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/28/19	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Chesapeake City	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 345 Basil Avenue				10f. ZIP CODE 21915		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES US Army WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Interior/Exterior Homes			
17. FATHER'S NAME (First, Middle, Last) John R. Eveland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna T. Roberts			
19a. INFORMANT'S NAME (Type/Print) Gertrude J. Eveland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 345 Basil Avenue, Chesapeake City, MD 21915			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery		20c. LOCATION — City or Town, State 3/31/95 Chesapeake City, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. ascvd DUE TO (OR AS A CONSEQUENCE OF): c. valvular heart disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 30 min Years Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER p. a. ryals, md				29c. LICENSE NUMBER br 3774711		29d. DATE SIGNED (Month, Day, Year) mar 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) p. a. ryals, md / union hospital / elkton, md 21921							
31. DATE FILED (Month, Day, Year) mar 27, 1995		32. REGISTRAR'S SIGNATURE MAR 31 1995 John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10  
+1VA



95 11192

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marguerite A. Eldredge</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>22</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1454p</i> M	
4. SOCIAL SECURITY NUMBER <i>144-09-1147</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>November 29, 1909</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Takoma Park</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>New Jersey</i>				10b. COUNTY <i>Cape May</i>		10c. CITY, TOWN OR LOCATION <i>Cape May</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>608 Washington St. # 313B</i>				10f. ZIP CODE <i>08204</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Henri Iecog</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Leontine Bailleul</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Annie Kahn</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7616 15th Ave. Takoma Park, MD 20912</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cape May Courthouse Baptist Cemetery March 27, 1995</i>		20c. LOCATION — City or Town, State <i>Cape May Courthouse, NJ</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Debra A. Freibach</i>				22. NAME AND ADDRESS OF FACILITY <i>Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIAL ARREST</i>							Approximate Interval Between Onset and Death
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <i>ATHROSCLEROTIC HEART DISEASE</i>							<i>5 yrs</i>
b. <i>NON INSULIN DEPENDENT DIABETES MELLITUS</i>							<i>15 yrs</i>
c. <i>HYPERTENSION</i>							<i>20 yrs</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Recent Cerebral Vascular Accident</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i></i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Reginald D. Barnes Jr. MD</i>				29c. LICENSE NUMBER <i>DA 43711</i>		29d. DATE SIGNED (Month, Day, Year) <i>MARCH 24 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>REGINALD D. BARNES JR MD 7616 CARROLL AVE #310 TAKOMA PARK, MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 27 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Stevenson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11193

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mansur Ekhtiar</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>24</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1750 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>316-42-8111</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 15, 1924</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Potomac</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11711 Devilwood Drive</i>				10f. ZIP CODE <i>20854</i>		10g. CITIZEN OF WHAT COUNTRY? <i>Iran</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Professor/Administrator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>University</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Muhammad Ekhtiar</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hamideh Tehrani</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Shelly Ekhtiar</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11711 Devilwood Drive, Potomac, Maryland 20854</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>National Memorial Park</i>		20c. LOCATION — City or Town, State <i>Falls Church, Virginia</i>		20d. DATE <i>March 26, 1995</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i>				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Intracerebral hemorrhage.</i>					
		b. <i>closed head trauma.</i>					
		c. <i>Auto accident</i>					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Thrombocytopenia, possible sepsis. Soft tissue injury. Coronary artery disease</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>3/12/95</i>		28b. TIME OF INJURY <i>1400</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <i>Hit broad side</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Street/Road</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>I-70 / Rt 75 Fred Ct</i>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D26806</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alan D. [Signature] 747 Northern Ave Hagerstown MD 21742</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 27 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


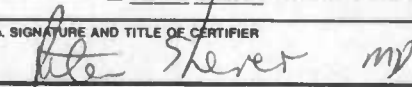
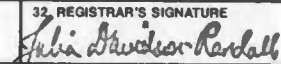




95 11194

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Arthur Elion</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>25</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>8:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>082-14-6243</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 18, 1918</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7105 Wilson Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Pennsylvania</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Narbeth</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>515 Sprague Road</b>				10f. ZIP CODE <b>19072</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Executive</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Printing Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Abraham Elion</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Fannie "Unknown"</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Richard Elion (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7105 Wilson Lane Bethesda, MD. 20817</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Haym Salomon Cemetery 3/28</b>		20c. LOCATION — City or Town, State <b>Frazer, Pa.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, MD 20852</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Liver Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER  <b>md</b>		29c. LICENSE NUMBER <b>021910</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 25, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter Sherer md 3947 Ferrara Dr. Wheaton, MD 20906</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

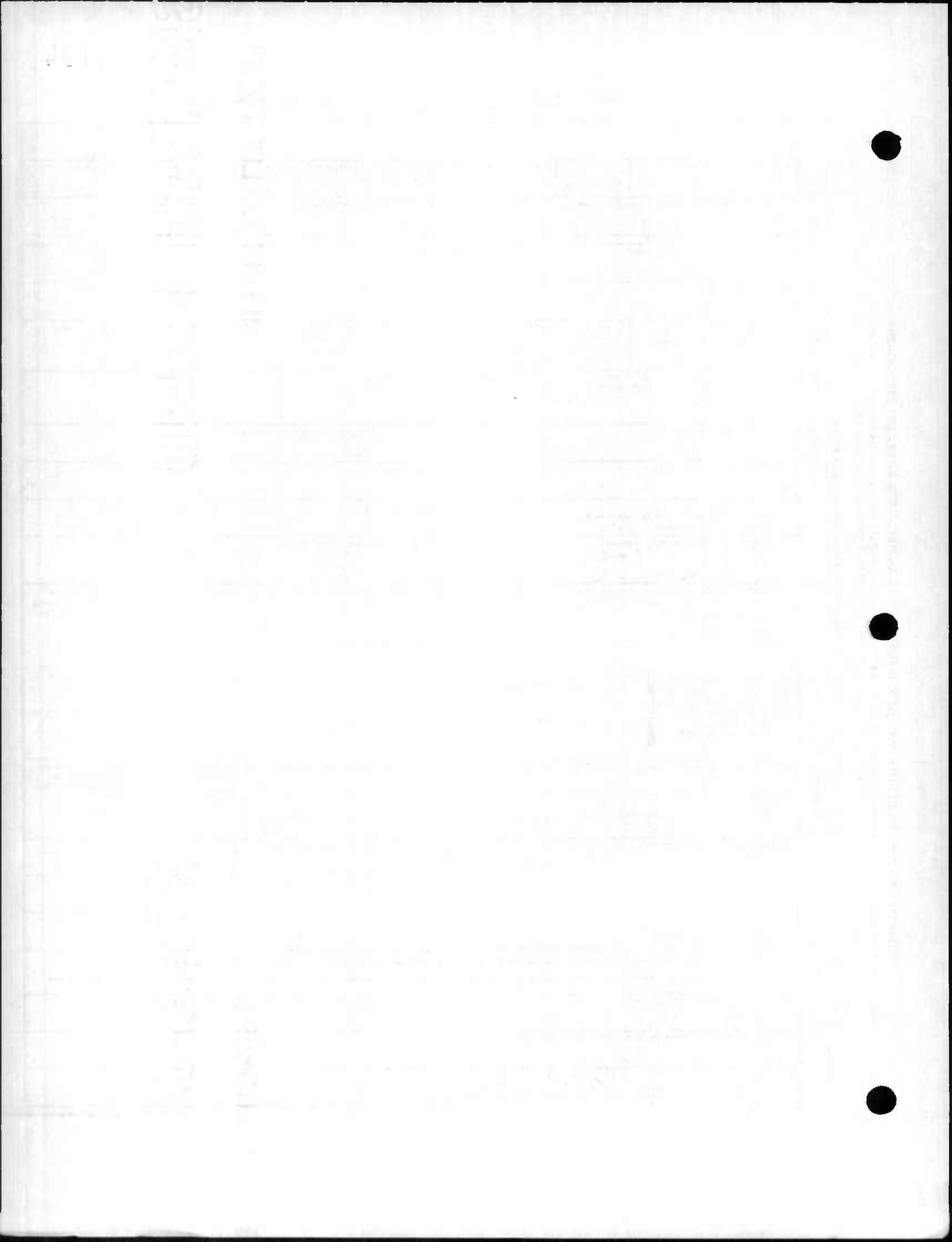
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11195

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beatrice Thompson Evans				2. DATE OF DEATH MONTH DAY YEAR March 28, 1995		3. TIME OF DEATH 6:15 A M	
4. SOCIAL SECURITY NUMBER 234-62-6378		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 7, 1911	
8a. FACILITY NAME (If not institution, give street and number) 7710 Chicago Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7710 Chicago Avenue				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) George Thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable			
19a. INFORMANT'S NAME (Type/Print) Brenda E. Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 Chicago Ave., Silver Spring, MD 20910			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenwood Cemetery		DATE 3/31		20c. LOCATION — City or Town, State Beckley, West Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry P. Dobbins</i>				22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc. 20012 7400 Georgia Ave. N.W., Washington, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final result in death) →		a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Parkinson's Disease DUE TO (OR AS A CONSEQUENCE OF):					5 years
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion A. Parrott M.D.</i>				29c. LICENSE NUMBER D17835		29d. DATE SIGNED (Month, Day, Year) March 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marion Parrott, MD 2150 Pennsylvania Ave. N.W. Ste. R-5-425 Washington, D.C. 20037							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE <i>J. J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO  
LIBRARY

1954

THE UNIVERSITY OF CHICAGO  
LIBRARY

95 11196

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARMIAN ELKES</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>19</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2:35 P.</b>	
4. SOCIAL SECURITY NUMBER <b>216-40-6894</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 22, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>LONDON, ENGLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3312 Camalier Drive</b>	
10f. ZIP CODE <b>20815</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Physician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Alek Bourne</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Haywood</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anna R. Parris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3307 Cummings Lane, Chevy Chase, MD 20815</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Geo. Wash. Univ. Medical Center</b>		20c. LOCATION — City or Town, State <b>Washington, DC</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Columbia Mortuary Services, Inc. 225 Missouri Ave., N.W., Washington, DC 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Acidosis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>hypothyroidism</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypothyroidism</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D26992</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/21/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KATHRYN S KLEIN 10400 Conn Ave Kensington MD 20895</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

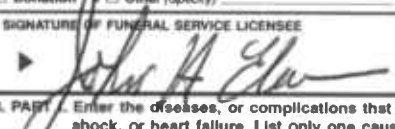
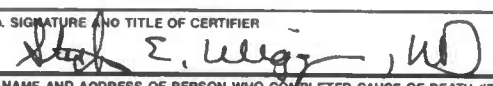
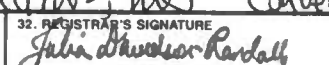
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11197

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KERRY Nicholas EISENACHER</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:31 AM</b>	
4. SOCIAL SECURITY NUMBER <b>578-54-1292</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 8 1941</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LA PLATA</b>		9c. COUNTY OF DEATH <b>CHARLES</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Waldorf</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1012 IVY LANE</b>			
10f. ZIP CODE <b>20602</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Systems Technician</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Communications</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George W. Eisenacher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Barrows Eisenacher</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Martha Eisenacher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1012 Ivy Lane Waldorf, MD 20602</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 3-31-95</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>		20d. DATE <b>3-31-95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0173</b>		22. NAME AND ADDRESS OF FACILITY <b>J.H. Eberwein Mortuary 4433 White Pls. La. White Pls., MD 20695</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Ventricular Fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Atherosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1) S/P M.I. 3) COPD 5) Hyperlipidemia 7) stroke 2) CHF 4) HT 6) S/P CABG</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Stephen E. Wiggins, MD</b>		29c. LICENSE NUMBER <b>025023</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen E. Wiggins, MD, Consultant HealthCare Waldorf, MD 20602</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11198

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DONALD JEROME ELLIOTT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 2, 1995</b>		3. TIME OF DEATH <b>11:50 PM</b>				
4. SOCIAL SECURITY NUMBER <b>578-42-8322</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 27, 1932</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAPLATA</b>		9c. COUNTY OF DEATH <b>CHARLES</b>				
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>La Plata,</b>				
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										
10e. STREET AND NUMBER <b>5236 Colebrook Drive</b>				10f. ZIP CODE <b>20646</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sheet Metal Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Government</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Wallace Walker Elliott</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alma Dalma Sturgis</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Rosemarie Z. Elliott</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5236 Colebrook Drive, La Plata, MD 20646</b>						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans' Cem.</b>		20c. LOCATION — City or Town, State <b>4-5-95 Cheltenham, MD</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn M00053</b>				22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home, Inc. P. O. box 156, Waldorf, MD 20604-0156</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>CEREBRAL INFARCTION</b>  c.  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>D-28281</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/3/95</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NELSON V. BENJERS MD. 8926 WOODYARD ROAD #102 CLINTON MD. 20735</b>										
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


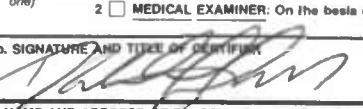
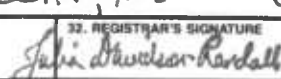
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11199

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Neal Fox				2. DATE OF DEATH MONTH DAY YEAR April 1 1995		3. TIME OF DEATH 11:46 a. m.	
4. SOCIAL SECURITY NUMBER 213-26-6236		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 4, 1929	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Residence: 520 Front Street		9b. CITY, TOWN OR LOCATION OF DEATH Perryville	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Perryville				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		10e. STREET AND NUMBER 520 Front Street	
10f. ZIP CODE 21903				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1948 - 1951				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Branch Supervisor of Supplies		16b. KIND OF BUSINESS/INDUSTRY Aberdeen Proving Ground Aberdeen, Maryland	
17. FATHER'S NAME (First, Middle, Last) Dewey N. Fox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Hornbarger			
19a. INFORMANT'S NAME (Type/Print) Sandra Fox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Starboard Court, Perryville, Maryland 21903			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removed from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cokesbury United Methodist Cemetery 4/3/95 Abingdon, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound - SELF INFLICTED DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, Alcohol Abuse							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 X DOA OTHER: 4 Nursing Home 5 X Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 8 4 Homicide				28a. DATE OF INJURY (Month, Day, Year) APR 1 95		28b. TIME OF INJURY 1000 A.M.	
28c. INJURY AT WORK? 1 YES 2 X NO				28d. DESCRIBE HOW INJURY OCCURRED SELF INFLICTED			
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Residence				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 520 FRONT ST PERRYVILLE			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D35040		29d. DATE SIGNED (Month, Day, Year) APR 2 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D H RATCLIFF, MD UNION HOSPITAL BAUST ELKTON, MD.							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11200

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CECILIA FROMME</b>		2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>22</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:48 PM</b>	
4. SOCIAL SECURITY NUMBER <b>103-32-6755</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 9, 1903</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>		9. FACILITY NAME (If not Institution, give street and number) <b>7909 STONE HEARTH ROAD</b>	
10. CITY, TOWN OR LOCATION OF DEATH <b>SEVERN</b>		11. COUNTY OF DEATH <b>ANNE ARUNDEL</b>		12. RESIDENCE OF DECEDENT	
13. STATE <b>FLORIDA</b>		14. COUNTY <b>DADE</b>		15. CITY, TOWN OR LOCATION <b>NORTH MIAMI BEACH</b>	
16. STREET AND NUMBER <b>500 BAYVIEW DRIVE #818</b>		17. ZIP CODE <b>33160</b>		18. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) <b>4</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		24. KIND OF BUSINESS/INDUSTRY <b>NEW YORK CITY BOARD OF EDUCATION</b>	
25. FATHER'S NAME (First, Middle, Last) <b>ALEXANDER TRIER</b>		26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LENA STRAUSS</b>		27. INFORMANT'S NAME (Type/Print) <b>ROBIN F. SCHNEIDERMAN</b>	
28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7909 STONE HEARTH ROAD-SEVERN, MARYLAND 21144</b>		29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HUNGARIAN UNION FIELD CEM 3/24</b>	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		32. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>		33. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
34. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>		35. DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____		36. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST _____	
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>		38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>		41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
43. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		44. 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M _____ 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		45. 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
46. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		47. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		48. 29c. LICENSE NUMBER <b>D-40521</b>	
49. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. OCHANEY 7845 OAKWOOD ROAD SUITE 200 GREEN BELT, MD 21061</b>		50. 31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		51. 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11201

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helena M. Farmer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 21, 1995</b>		3. TIME OF DEATH <b>9:30P</b>	
4. SOCIAL SECURITY NUMBER <b>220-38-2825</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 17, 1895</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Rockville Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>408 Great Falls Road</b>	
10f. ZIP CODE <b>20850</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>School</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Charlton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Molly Staggers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William T. Nicholson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Great Falls Road, Rockville, Maryland 20850</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc. March 25, 1995</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Dementia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Arteriosclerosis</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input checked="" type="checkbox"/> XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frauke Westphal M.D.</i>				29c. LICENSE NUMBER <b>D19485</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 22, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frauke Westphal, M.D. 809 Viers Mill Road, Rockville, Maryland 20851</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annie Josephine FLERI				2. DATE OF DEATH MONTH DAY YEAR March 24, 1995		3. TIME OF DEATH 4:17 P M	
4. SOCIAL SECURITY NUMBER 579-18-0106		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 28, 1902	
8. BIRTHPLACE (State or Foreign Country) Italy				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2215 Glenallen Avenue, Apt. 201	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Custom Tailoring	
17. FATHER'S NAME (First, Middle, Last) Giuseppe Baronello Baronello				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nunzia Romeo			
19a. INFORMANT'S NAME (Type/Print) Nancy V. Fleri				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Glenallen Ave, #201, Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Mem. Park 03-28-95		20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John F. Luther</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>arteriosclerotic heart disease</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George F. Sengstack M.D.</i>				29c. LICENSE NUMBER D12121		29d. DATE SIGNED (Month, Day, Year) 3-24-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George F. Sengstack, 3929 Ferrara Drive, Wheaton, MD 20906-4709							
31. DATE FILED (Month, Day, Year) MAR 30 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11203

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUISE THOMAS FARLOW</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 27 1995</b>		3. TIME OF DEATH <b>12:45 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-46-4948</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 18, 1903</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>11039 WORCESTER HIGHWAY</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BERLIN</b>		8c. COUNTY OF DEATH <b>WORCESTER</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>WORCESTER</b>		10c. CITY, TOWN OR LOCATION <b>BERLIN</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11039 WORCESTER HIGHWAY</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM E. THOMAS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY H. DUKES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LINDA L. SELLERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11039 WORCESTER HIGHWAY, BERLIN, MARYLAND 21811</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BUCKINGHAM CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>BERLIN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Hastings</i>				22. NAME AND ADDRESS OF FACILITY <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter S. Abbott MD</i>				29c. LICENSE NUMBER <b>P30819</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER S ABBOTT MD 10445 Ocean City Blvd Berlin, Md 21811</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11204

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH Paul Gooch</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>20</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:45A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-38-0851</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>51</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>January 2, 1944</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>135 Willowdale Drive</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b> <b>College (1-4 or 5+) 12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Carpet/ Floor Covering</b>	
17. FATHER'S NAME (First, Middle, Last) <b>David W. Gooch, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bernice Foster</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kelly I. Tolarski/Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>502 Quince Ct. LaPlata, MD 20646</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Cemetery March 24, 1995 Adelphi, MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Takoma Funeral Home, Inc. 254 Carroll St. N.W. Washington, D.C. 20012</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE PULMONARY EMBOLI</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. NONSMALL CELL LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death <b>15 months</b> <b>1 yr 1 mo</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carolyn B. Hendricks MD</i>		29c. LICENSE NUMBER <b>D37236</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MARCH 20, 1995</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CAROLYN B. HENDRICKS 9707 Medical Center Drive Rockville MD 20850</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11205

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William F. Gibson				2. DATE OF DEATH MONTH DAY YEAR March 27, 1995		3. TIME OF DEATH 1:30 a. M	
4. SOCIAL SECURITY NUMBER 726-09-0090		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 14, 1910	
8a. FACILITY NAME (If not institution, give street and number) 617 8th Street				8b. CITY, TOWN OR LOCATION OF DEATH Laurel		8c. COUNTY OF DEATH Prince Georges	
9. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 617 8th Street			
10f. ZIP CODE 20707				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stationary Engineer		16b. KIND OF BUSINESS/INDUSTRY Dept. of Agriculture			
17. FATHER'S NAME (First, Middle, Last) Edmond Gibson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Neval Smith			
19a. INFORMANT'S NAME (Type/Print) Gordon E. Gibson (son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8507 Montpelier Dr., Laurel, MD 20708			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Nat'l Mem. Park		20c. DATE 3/31		20d. LOCATION — City or Town, State Laurel, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ischemic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death years years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i> <i>Diabetes mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. DATE SIGNED (Month, Day, Year) 3/28/95			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. G. Gattis</i>				29c. LICENSE NUMBER D06644		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bruce W. Gattis MD, 8383 Cherry Lane, Laurel, MD 20707							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE <i>John A. Riddell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11206

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edith Gartenkraut</b>			2. DATE OF DEATH MONTH DAY YEAR <b>March 26 1995</b>			3. TIME OF DEATH <b>07:12 P M</b>				
4. SOCIAL SECURITY NUMBER <b>321-30-4215</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 5, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Poland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>			9c. COUNTY OF DEATH <b>Montgomery</b>			
RESIDENCE OF DECEDENT										
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>11 Old Creek Court</b>				10f. ZIP CODE <b>20854</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Baby Sitter</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Child Care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Lubelchek</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hannah Zuckerman</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Blima Wellek</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Westlawn Cemetery</b>			20c. DATE <b>3-29</b>		20d. LOCATION — City or Town, State <b>Chicago, Illinois</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen W. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute myocardial infarct</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Hypertensive Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>HR5</b> <b>10 yrs</b>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Steven G. Gevas MD</b>				29c. LICENSE NUMBER <b>D29643</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27 1995</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Steven G. Gevas MD 9901 Medical Center Dr. Rockville, Md. 20850</b>										
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11207

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALEJANDRO S. GARCIA, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAR 28 1995</b>		3. TIME OF DEATH <b>23:49</b> M	
4. SOCIAL SECURITY NUMBER <b>577-88-0060</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1959</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>11939 Old Columbia Pike</b>			
10f. ZIP CODE <b>20904</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Cuban</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pension Trust Fund</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Alejandro S. Garcia, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ana R. DePaz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ana C. Hall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8100 Dayton Street Mason Neck, Virginia 22079</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 3/31/95 Silver Spring, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark S. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>acquired immune deficiency syndrome</b>					
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute myocardial infarction</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>501499</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 29 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lewis H. Dennis, M.D. 6201 Greenbelt Rd. #U-1 College Park MD 20740</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11208

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Blan Lonnie Gambill</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 29, 1995</b>		3. TIME OF DEATH <b>6:25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>212-38-0772</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 23, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Franklin Woods</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rosedale</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Bel Air</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2108 White House Road</b>	
10f. ZIP CODE <b>21015</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (14 or 5+) <b>College (14 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dairy Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lonnie Lee Gambill</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lovannie Cedell Taylor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lucille B. Gambill</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2108 White House Road, Bel Air, Maryland 21015</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens 3/31/95</b>		20c. LOCATION — City or Town, State <b>Bel Air, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GASTROINTESTINAL BLEEDING</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>GASTRITIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>							
d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>SUBDURAL HEMATOMA</b>							
<b>ASPIRATION</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carol Richardson MD</b>				29c. LICENSE NUMBER <b>D46304</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 29, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9000 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11209

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sarah Gross</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 30 1995</b>		3. TIME OF DEATH <b>1:15 pm</b>	
4. SOCIAL SECURITY NUMBER <b>218-28-4333</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (in yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 20, 1929</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1 Hickory Lane Apt LL 5</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LA Plata</b>		9c. COUNTY OF DEATH <b>Charles</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>LA Plata</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1 Hickory Lane Apt LL 5</b>				10f. ZIP CODE <b>20646</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Rubin Dorsey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carde Hicks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY Hoban</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6657 Animal Shelter Rd, Hughesville MD 20637</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Mary Cath Ch. April 4, 1995</b>		20c. LOCATION — City or Town, State <b>Bryantown MD</b>		20d. DATE <b>April 4, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lloyd Esler</b>				22. NAME AND ADDRESS OF FACILITY <b>Adams Funeral Home, Agassaw MD 20608</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiorespiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert Antunard</b>		29c. LICENSE NUMBER <b>D13675</b>		29d. DATE SIGNED (Month, Day, Year) <b>30 March 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PO Box 1737 White Plains RD 20695</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11210

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE HOWARD GEARLD, JR.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>17</b> YEAR <b>95</b>		3. TIME OF DEATH <b>0230 A M</b>	
4. SOCIAL SECURITY NUMBER <b>248-12-9533A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPTEMBER 3, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>(Home) 731 BOOTH STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>731 BOOTH STREET</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>UNKNOWN</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CARPENTER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>SELF-EMPLOYED</b>	
16. FATHER'S NAME (First, Middle, Last) <b>GEORGE HOWARD GEARLD, SR.</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PEARL ELZEY</b>			
17a. INFORMANT'S NAME (Type/Print) <b>NOVELLA DASHIELDS</b>				17b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>731 BOOTH ST - SALISBURY MD 21801</b>			
18a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				18b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CAPITOL CREMATORY</b>		18c. LOCATION — City or Town, State <b>324 DOVER, DE</b>	
19. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Russell G. Fooker</b>				20. NAME AND ADDRESS OF FACILITY <b>FOOKER FUNERAL SERVICE</b> <b>917 W. Isabella St - Salis, MD 21801</b>			
21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Angina Pectoris</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Alzheimers Disease</b> DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>E. G. G. M.</b>				29c. LICENSE NUMBER <b>215001</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-24-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E. T. G. M., 540 Riverside Drive, Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]

95 11211

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES FISHER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 24 1995</b>		3. TIME OF DEATH <b>1839 M</b>	
4. SOCIAL SECURITY NUMBER <b>325-18-6732</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>71</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8-21-1923</b>	8. BIRTHPLACE (State or Foreign Country) <b>ILLINOIS</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>836 SCHUMAKER DR.</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WORLD WAR II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>POULTRYMAN</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWN FARM</b>		17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>FLOYD GURLEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLOSSIE WELTY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY GURLEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>836 SCHUMAKER DR. SALISBURY, MD. 21801</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK</b>		20c. DATE <b>3-27</b>		20d. LOCATION — City or Town, State <b>SALISBURY, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald C. Saunders</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Ruptured AAA</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Ruptured colon</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 week</b> <b>1 "</b> <b>1 month</b> <b>3 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shawn L. Pearson</i>				29c. LICENSE NUMBER <b>D30693</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>560 Riverside Dr Salisbury MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kyle Judson Hash				2. DATE OF DEATH MONTH DAY YEAR March 30 1995		3. TIME OF DEATH 9:30 a m	
4. SOCIAL SECURITY NUMBER 186-07-2965		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1910	
8. BIRTHPLACE (State or Foreign Country) North Carolina		9a. FACILITY NAME (If not institution, give street and number) Residence: 825 Rowland Road		9b. CITY, TOWN OR LOCATION OF DEATH Colora		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Colora	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 825 Rowland Road		10f. ZIP CODE 21917	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nine Years -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-Employed		16b. KIND OF BUSINESS/INDUSTRY Farmer	
17. FATHER'S NAME (First, Middle, Last) Fields H. Hash				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dona Jones			
19a. INFORMANT'S NAME (Type/Print) Betty Sue Gentry Hash				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Rowland Road, Colora, Maryland 21917			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hopewell Cemetery 4/3/95		20c. LOCATION — City or Town, State Port Deposit, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas M. Patterson, Sr.				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of colon with liver and abdominal metastases Since Feb. 1993 b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1) Hypertensive arteriosclerotic cardiovascular disease 2) Diabetes mellitus type II DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Long D. Kim, M.D.				29c. LICENSE NUMBER D15103		29d. DATE SIGNED (Month, Day, Year) 3/31/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sang W. Kim, M.D., 308 South Union Avenue, Havre de Grace, Maryland 21078							
31. DATE FILED (Month, Day, Year) APR 03 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11213

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Ruth Emily Holderman</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>29</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>8:20 A</u> M	
4. SOCIAL SECURITY NUMBER <u>223-54-6203</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>90</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 28, 1904</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Ohio</u>				9a. FACILITY NAME (If not Institution, give street and number) <u>Manor Care Potomac</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Potomac</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>	
10c. CITY, TOWN OR LOCATION <u>Bethesda</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>9204 Wadsworth Drive</u>	
10f. ZIP CODE <u>20817</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1</u> College (1-4 or 5+) <u>1</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>George Motter</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Marietta Ridenour</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Richard A. Holderman</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>914 Lawton Street, McLean, VA 22101</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metropolitan Crematory 3/30/95</u>			
20c. LOCATION — City or Town, State <u>Alexandria, Virginia</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>			
22. NAME AND ADDRESS OF FACILITY <u>DeVol Funeral Home</u> <u>2222 Wisconsin Ave., N.W.</u> <u>Washington, DC 20007</u>				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Acute myocardial infarction (presumed)</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c.</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d.</u>			
Approximate Interval Between Onset and Death <u>minutes</u> <u>years</u>				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hypertension</u> <u>congestive heart failure</u>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <u>March 29, 1995</u>			
28b. TIME OF INJURY <u>M</u>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>David A. Blass M.D.</u>				29c. LICENSE NUMBER <u>D23911</u>			
29d. DATE SIGNED (Month, Day, Year) <u>March 29, 1995</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>David A. Blass, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814</u>			
31. DATE FILED (Month, Day, Year) <u>MAR 31 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED

JUL 3 1995

MEDICAL ASSISTANCE  
RECOVERIES



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD Hayes</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>20</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>1:40 P M</b>			
4. SOCIAL SECURITY NUMBER <b>093-24-4160</b>		5. SEX <b>1 M 2 F</b>	6. AGE (In yrs. last birthday) <b>64</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 13, 1931</b>		8. BIRTHPLACE (State or Foreign Country) <b>Albany, New York</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>218 NORTH CHARLES STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH			
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>			
10e. STREET AND NUMBER <b>218 N. Charles Street #2302</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 X Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Peronnel Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Donald Burdett Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Beatrice Hayes</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Robert Atherton Hall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20415 Meadow Pond Place, Gaithersburg, MD 20879</b>							
20a. METHOD OF DISPOSITION <b>1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 3/22/95</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Cribbens</i>				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES NO UNCERTAIN</b>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 X YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 X Residence 6 Other (Specify)</b>									
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>DAVID R. FOWLER</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 21, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID R. FOWLER M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11215

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rita C. Howell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1995</b>		3. TIME OF DEATH <b>8:29p. M</b>	
4. SOCIAL SECURITY NUMBER <b>019-24-2770</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 8, 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>4815 Ruatan Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>College Park</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>College Park</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4815 Ruatan Street</b>	
10f. ZIP CODE <b>20740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Copier Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert Cartier</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Louise Tousignant</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Herbert M. Howell, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery March 30, 1995 Arlington, Virginia</b>		20c. LOCATION — City or Town, State		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>	
22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hepatic Failure Secondary Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Bilateral Malignant Pleural Effusions</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Metastatic Breast Cancer-Skeleton</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Breast Cancer, AdenoCarcinoma</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death <b>3weeks</b> <b>1year</b> <b>7years</b> <b>12years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Norman J. Martin MD.</i> COL US ARMY MED CORPS.		29c. LICENSE NUMBER <b>125-36-9000</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter Reed Army Medical Center Washington, D.C. 20307</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

95-1727-031

B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-722 4/19/95 t.t

95 11216

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) PATSY MARIE HOLLAND				2. DATE OF DEATH MONTH DAY YEAR MARCH 26, 1995		3. TIME OF DEATH 1400 P M	
4. SOCIAL SECURITY NUMBER 214-48-2233		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1947	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2027 Harlequin Terrace				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Charles Lyles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Holland			
19a. INFORMANT'S NAME (Type/Print) James Holland (Brother)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14308 Astrodome Dr., Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bushy Park Cemetery 4/1		20c. LOCATION — City or Town, State Cokesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George L. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDITIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MARCH 27, 1995	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>				29c. LICENSE NUMBER O.C.M.E			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Harrell</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELINOR EUGENTH HOFFNER</b>				2. DATE OF DEATH MONTH <b>3</b> -DAY <b>21</b> -YEAR <b>1995</b>		3. TIME OF DEATH <b>7:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-18-6346</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>1-22-1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>At Home- 20440 Nanticoke Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Nanticoke</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Nanticoke</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20440 Nanticoke Road</b>				10f. ZIP CODE <b>21840</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Ephrian Bounds</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucy Ellen Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Fred A. Hoeffner JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3476 Windmill Hill Road, Bivalve, Md 21814</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salisbury Crematory 3/24 Salisbury, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Comelius J. [Signature]</i> MOO-417				22. NAME AND ADDRESS OF FACILITY <b>Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Diabetes Mellitus</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b> <b>Arteriosclerotic Cerebrovascular Disease</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S.H. Laffey</i>				29c. LICENSE NUMBER <b>D20683</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/22/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S.H. LAFFEY MD PO Box 121 Nanticoke Md 21840</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 23 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					





95 11218

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY HARPER</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>22</b> YEAR <b>95</b>		3. TIME OF DEATH <b>4:15 P.</b>	
4. SOCIAL SECURITY NUMBER <b>215-54-7769</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 4, 1908</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Greater Laurel Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>		8c. COUNTY OF DEATH <b>Prince George</b>	
9a. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Prince George</b> 10c. CITY, TOWN OR LOCATION <b>Laurel</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>13013 Old Stagecoach Rd Apt 1913</b>	
10f. ZIP CODE <b>20708</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Domestic</b>		16. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George Middleton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Neida Bonds</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kenneth Harper</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13013 Old Stagecoach Rd Apt 1913 Laurel MD 20708</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Myers United Meth Ch. 3/23/95 Upper Marlboro MD</b>		20c. LOCATION — City or Town, State		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thoyl Estep</b>	
22. NAME AND ADDRESS OF FACILITY <b>Adams Funeral Home, Aquasco MD 20608</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Due to (or as a consequence of):</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>unknown</b> <b>1 day</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Samuel S. M.D.</b>		29c. LICENSE NUMBER <b>D37697</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/23/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SAMUEL S. M.D.</b>		31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>					
32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

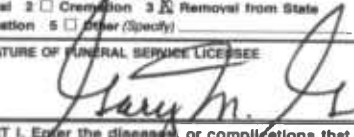


TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROCKEY KURLIN-HAIS</b>				2. DATE OF DEATH <b>MARCH 26, 1995</b> YEAR <b>10:15 A</b> M				3. TIME OF DEATH			
4. SOCIAL SECURITY NUMBER <b>132-09-2058</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 24, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>			9c. COUNTY OF DEATH <b>MONTGOMERY</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>BETHESDA</b>			10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>4400 EAST WEST HIGHWAY #516</b>				10f. ZIP CODE <b>20814</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>					
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEVELOPER</b>			16b. KIND OF BUSINESS/INDUSTRY <b>REAL ESTATE</b>					
17. FATHER'S NAME (First, Middle, Last) <b>JOHN KURLIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAUDE "UNKNOWN"</b>							
19a. INFORMANT'S NAME (Type/Print) <b>SIDNEY HAIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4400 EAST WEST HIGHWAY #516-BETHESDA, MD. 20814</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input checked="" type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GARDEN 3/29</b>		DATE <b>3/29</b>		20c. LOCATION — City or Town, State <b>FALLS CHURCH, VIRGINIA</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852</b>							
23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRACEREBRAL BLEED</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. <b>DIABETES MELLITUS</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death <b>1 DAY</b> <b>UNKNOWN</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D37532</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 27, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PRAVEEN GUPTA, MD - 50 W. EDMONSTON DRIVE #202 - ROCKVILLE, MARYLAND 20852</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE 									



95 11220

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Marian Waters Jacobs</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>25</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>1:25</u> <u>A</u> M	
4. SOCIAL SECURITY NUMBER <u>213-38-4830</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>69</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 23, 1925</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Shady Grove Adventist Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>	
10c. CITY, TOWN OR LOCATION <u>Washington Grove</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>103 Brown Street</u>	
10f. ZIP CODE <u>20880</u>				10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Teacher</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Mongomery Co. Public Schools</u>	
17. FATHER'S NAME (First, Middle, Last) <u>William Alexander Waters</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lillian Fields</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Charles Talmadge Jacobs</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>103 Brown Street, Washington Grove, MD 20880</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. Mary's Cemetery 3/28/95</u>		20c. LOCATION — City or Town, State <u>Rockville, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Michael D. Gibbons</u>				22. NAME AND ADDRESS OF FACILITY <u>DeVol Funeral Home</u> <u>10 East Deer Park Drive</u> <u>Gaithersburg, MD 20877</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Adenocarcinoma of Unknown Primary site (metastatic)</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u> <u>Hypertension</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>Byrl D. Johnson M.D.</u>		29c. LICENSE NUMBER <u>0-19042</u>	
29d. DATE SIGNED (Month, Day, Year) <u>March 25, 1995</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>BYRL D. JOHNSON 911 Russell Avenue Gaithersburg, MD. 20879</u>			
31. DATE FILED (Month, Day, Year) <u>MAR 27 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11221

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HOWARD E. Johnson Sr</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>24</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0135A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-18-2022</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 14, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Dickerson</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20470 Beallsville Road</b>				10f. ZIP CODE <b>20842</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>Trackman</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Trackman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B&amp;O Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Johnson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Plummer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ethel L. Johnson (Wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20470 Beallsville Rd., Dickerson, MD 20842</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 3/30</b>		20c. LOCATION — City or Town, State <b>Dickerson, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>5 DAYS</b> <b>5 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Carl I. Schoenberger MD</i>				29c. LICENSE NUMBER <b>D26540</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 24 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carl I. Schoenberger 16220 Frederick Rd. Gaithersburg</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11222

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louise S. Jenkins</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>26</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-14-7484</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUGUST 16, 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Kensington Gardens Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Kensington</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Kensington</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>10817 Hobson Street</b>				10f. ZIP CODE <b>20895</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Reinhold Paul Springirth</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Maedel</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Courtney G. Springirth</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>133 Crystal Spring Drive Ashton, Maryland 20861</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Cemetery 3/29/95</b>		20c. LOCATION — City or Town, State <b>Rockville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypertensive Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>24 Hours</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George F. Sengstack, M.D.</i>				29c. LICENSE NUMBER <b>D 12121</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George F. Sengstack, M.D. 3929 Ferrara Drive Wheaton, Maryland 20902</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11223

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Julius Jancin, Jr.</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>23</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:30 a</b> M	
4. SOCIAL SECURITY NUMBER <b>288.12.3090</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 13, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7815 Fulbright Court</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7815 Fulbright Court</b>				10f. ZIP CODE <b>20817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>+5</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Attorney</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Patent Attorney</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Julius Jancin, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Braidec</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Evelyn D. Jancin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7815 Fulbright Court Bethesda, Md. 20817</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 3/27</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph M. Peters</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons 5130 WI AVE N.W. WASHINGTON D.C.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE LEUKEMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. MYELODYSPLASTIC SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d. _____</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>4 MONTHS</b> <b>7.5 MONTHS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samuel A. [Signature]</i> 29c. LICENSE NUMBER <b>D 29675</b> 29d. DATE SIGNED (Month, Day, Year) <b>MARCH 23, 1995</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ralph V. Boccia, M.D. 10605 Concord St. #300 Kensington, Md. 20895-2594</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11224

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucille Jefferson</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:30 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>144-34-6595</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 9, 1942</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>10109 Bignonia Drive</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>		8c. BIRTHPLACE (State or Foreign Country) <b>So. Carolina</b>	
9a. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Prince Georges</b>				10c. CITY, TOWN OR LOCATION <b>Laurel</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10109 Bignonia Drive</b>				10f. ZIP CODE <b>20708</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrative Aide</b>		16b. KIND OF BUSINESS/INDUSTRY <b>P.G. Family Services</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Johnny Robinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Christine Page</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ulysees Jefferson (Husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10109 Bignonia Drive, Laurel, MD 20708</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD Nat'l Mem. Park 4/1</b>		20c. LOCATION — City or Town, State <b>Laurel, MD</b>		22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. COLON CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. METASTATIC TO LIVER</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Isabelle Martine</i>				29c. LICENSE NUMBER <b>D45014</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/29/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Isabelle Martine, M.D. 7350 Van Dusen Rd #420 Laurel MD 20707</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11225

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betty G. Jettmar</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>092-34-9665</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 8, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>924 Bywater Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>924 Bywater Road</b>			
10f. ZIP CODE <b>21401</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self-employed Owner</b>		16. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Krausner</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unobtainable</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Norman Jettmar</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>924 Bywater Road, Annapolis, Maryland 21401</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		DATE <b>4/1</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Avenue</b> <b>Silver Spring, Maryland 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC CANCER OF PANCREAS</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D41698</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 29 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen C. Hamilton, M.D. 205 Rudgley Avenue Annapolis, MD 21401 (410-268-3232)</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11226

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHRISTOPHER ADAM JOHNSON</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>21</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:29P</b> M	
4. SOCIAL SECURITY NUMBER <b>217-39-3897</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>1</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-10-1993</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>312 OHIO AVE.</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>KENNETH JOHNSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LAURA DUKES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAURA DUKES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>312 OHIO AVE. SALISBURY, MD. 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK</b>		DATE <b>3-24</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald C. Bunch</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>HIV INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>THROMBOCYTOPENIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHOLESTASIS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nancy Hutton MD</i>				29c. LICENSE NUMBER <b>D31002</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/21/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NANCY HUTTON, M.D., CMSC 144, JOHNS HOPKINS HOSPITAL, BALTO, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11227

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Worth Jamison III				2. DATE OF DEATH MONTH DAY YEAR March 26 1995		3. TIME OF DEATH 11:10 P.M.	
4. SOCIAL SECURITY NUMBER 212-36-9091		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/21/1928	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 33 John Owings Road		9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 33 John Owings Road		10f. ZIP CODE 21158	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) lawyer				16b. KIND OF BUSINESS/INDUSTRY law			
17. FATHER'S NAME (First, Middle, Last) T. Worth Jamison Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Penelope Westcott			
19a. INFORMANT'S NAME (Type/Print) Eleanor Jamison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 John Owings Road, Westminster, MD 21158			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 3/30/95		20c. LOCATION — City or Town, State Pikesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pritts - Switzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CA OF Lung Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Paraplegia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D18099		29d. DATE SIGNED (Month, Day, Year) 3-27-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOMENT J. S. [Signature] P.O. Box 511 Westminster							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE Julia Hamilton-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11228

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD R. (JONES, JR.)				2. DATE OF DEATH MONTH DAY YEAR March 28, 1995		3. TIME OF DEATH 2234 M	
4. SOCIAL SECURITY NUMBER 218-16-7916		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 16, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Ewell				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 20979 Caleb Jones Road	
10f. ZIP CODE 21824				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 6 College (1-4 or 5+) — — —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		16b. KIND OF BUSINESS/INDUSTRY Seafood	
17. FATHER'S NAME (First, Middle, Last) Edward Aaron Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary West Evans			
19a. INFORMANT'S NAME (Type/Print) Anna E. Jones (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20979 Caleb Jones Road P. O. Box 47 - Ewell, MD 21824			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ewell Church Cemetery - 4/2/95		20c. LOCATION — City or Town, State Ewell, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: years b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey E. Heston, M.D.				29c. LICENSE NUMBER D36783		29d. DATE SIGNED (Month, Day, Year) 3/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey E. Heston, M.D. PRMC, SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE John H. Heston			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13. The results of the experiments are presented in the following table.

14. The data show that the rate of reaction is directly proportional to the concentration of the reactants.

15.

16. The rate of reaction is also affected by the temperature of the system.

95 11229

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mildred Kane</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>31</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:05 a. m.</b>	
4. SOCIAL SECURITY NUMBER <b>578-12-2832</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 24, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1372 Redwood Circle</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>La Plata</b>		9c. COUNTY OF DEATH <b>Charles</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>LaPlata</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1372 Redwood Circle</b>				10f. ZIP CODE <b>20646</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Day Care Center</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self/ Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Herbert Webster</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nola B. Pettinsill</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles F. Kane</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1372 Redwood Circle, LaPlata, Maryland 20646</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cem April 3, 1995</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>		22. NAME AND ADDRESS OF FACILITY, Lee Funeral Home, Inc 6633 <b>Old Alexander Ferry Road, Clinton, Md 20735</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY, Lee Funeral Home, Inc 6633 <b>Old Alexander Ferry Road, Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D33426</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. Larry Jenkins, MD</b>				111 La Grange Ave. P.O. BOX 1724 <b>La Plata, M.D. 20646</b>			
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11230

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Jane Kuhns</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 3, 1995</b>		3. TIME OF DEATH <b>6:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-80-9141</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 4, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6404 S. Osborne Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Upper Marlboro</b>		9c. COUNTY OF DEATH <b>Prince George's</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Upper Marlboro</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>6404 S. Osborne Road</b>				10f. ZIP CODE <b>20772</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Vernon Skelly</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Effle Mann</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Clifton B. Kuhns</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6404 S. Osborne Road, Upper Marlboro, Md 20772</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Maryland Veterans Cem. Apr 6, 1995</b>		20c. LOCATION — City or Town, State <b>Cheltenham, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Karina D. McCarthy</b>				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. <b>Renal Failure</b></p> <p>b. <b>Stroke</b></p> <p>c. <b>Hypertension</b></p> </div> </div>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerosis</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rene Grace MD</b>				29c. LICENSE NUMBER <b>Do2257</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 4, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rene Grace MD 9131 Piscataway Road, Clinton, Md 20735</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11231

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STEVEN TODD KRILOWICZ				2. DATE OF DEATH MONTH DAY YEAR 3-21-1995		3. TIME OF DEATH 8:45 A M	
4. SOCIAL SECURITY NUMBER 183-58-9115		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 32 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4-14-1962	
8. BIRTHPLACE (State or Foreign Country) Pa.				9a. FACILITY NAME (If not institution, give street and number) Gumby Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury	
9c. COUNTY OF DEATH Wicomico				10a. STATE De.		10b. COUNTY Kent	
10c. CITY, TOWN OR LOCATION Harrington				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER RR 3 Box 207	
10f. ZIP CODE 19952				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hospital Corp		16b. KIND OF BUSINESS/INDUSTRY US NAVY	
17. FATHER'S NAME (First, Middle, Last) Robert Lee Krilowicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Joan Mary Nowicki Krilowicz			
19a. INFORMANT'S NAME (Type/Print) Robert Lee Krilowicz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gumby Ave. Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Henlopen Memorial Park 3-23		20c. LOCATION — City or Town, State Lewes, De.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas E. Melvin				22. NAME AND ADDRESS OF FACILITY Melvin Funeral Home P.O. Box 203 Harrington, De. 19952			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain lymphoma DUE TO (OR AS A CONSEQUENCE OF): b. A.I.D.S. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2195 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Hilda J. Melio				29c. LICENSE NUMBER 304883		29d. DATE SIGNED (Month, Day, Year) 3/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HILDA J. MELIO HOULIHAN M.D. 1405 S. DIVISION ST. SALISB MD							
31. DATE FILED (Month, Day, Year) MAR 22 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11232

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ETHEL FRANK KEEFER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:06 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-12-7967</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 20, 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Middleburg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5800 Middleburg Road</b>				10f. ZIP CODE <b>21757</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Health Care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Filmore Keefer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amanda Elizabeth Stoner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan K. Cox</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 35, Keymar, MD 21757</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Brethren</b>		DATE <b>4/1</b>		20c. LOCATION — City or Town, State <b>Union Bridge, MD 21791</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Skiles</i>				22. NAME AND ADDRESS OF FACILITY <b>136 E. Baltimore St. Skiles Funeral Home Taneytown, MD 21787</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>ATRIAL FIBILLATION</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 DAY</b> <b>2 YEARS</b> <b>4 YEARS</b> <b>2 YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Van Heller Schuchfoder MD</i>				29c. LICENSE NUMBER <b>D28221</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/29/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27), (Type, Print) <b>200 MEMORIAL AVE, WESTMINSTER, MD 21157</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11233

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel E. KEPHART				2. DATE OF DEATH MONTH DAY YEAR March 22, 1995		3. TIME OF DEATH 9:30 A. M	
4. SOCIAL SECURITY NUMBER 218-54-7439		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 31, 1901	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center		10. CITY, TOWN OR LOCATION OF DEATH Frederick	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1600 Bolton Street		10f. ZIP CODE 21702	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Gabriel U. Lawson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Holland			
19a. INFORMANT'S NAME (Type/Print) Vernon R. Kephart, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Bolton Street, Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 3/24/95			
20c. LOCATION — City or Town, State Rockville, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber			
22. NAME AND ADDRESS OF FACILITY Muriel H. Barber Funeral Home 20882 P. O. Box 5038, Laytonsville, Maryland				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Alimentia</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Alimentia</i> Approximate Interval Between Onset and Death <i>&gt; 10 yrs</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alimentia</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Arthur G. Manalo				29c. LICENSE NUMBER D-18181			
29d. DATE SIGNED (Month, Day, Year) March 23, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Arthur G. Manalo, M.D., 187 Thomas Johnson Drive, Frederick, MD 21702			
31. DATE FILED (Month, Day, Year) APR 12 1996				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11234

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JULE A. KLEE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 27 1995</b>		3. TIME OF DEATH <b>1:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>090-03-4611</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 01, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARINER GREATER LAUREL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE'S</b>		10c. CITY, TOWN OR LOCATION <b>LAUREL</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>14200 LAUREL PARK DRIVE</b>				10f. ZIP CODE <b>20701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Andrew Hosage</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eugene Klee</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8544 Pineway Court, Laurel, MD 20707</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sound Avenue Cemetery</b>		20c. LOCATION — City or Town, State <b>Riverhead, New York</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL INFARCT</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>						Approximate interval Between Onset and Death <b>ACUTE</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. A. L. M.</b>				29c. LICENSE NUMBER <b>D24997</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LUIS A. CASAS MD. 8317 CHERRY LANE LAUREL MD 20701</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Rodell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11235

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert J. Koerwer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 25, 1995</b>		3. TIME OF DEATH <b>12:50 P. M.</b>		
4. SOCIAL SECURITY NUMBER <b>165-14-9372</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 1, 1919</b>		
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3310 North Leisure World Blvd. #116</b>		
10f. ZIP CODE <b>20906-5659</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Network Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>American Telephone</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Harry Koerwer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Sparrow</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Ann E. Koerwer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery March 28, 1995</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>URINARY Tract Infection</b> <b>ATRIAL Fibrillation</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							Approximate Interval Between Onset and Death <b>3 days</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. [Signature]</i>				29c. LICENSE NUMBER <b>D18726</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/26/95</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) <b>18101 Prince Philip Dr., OLNEY, MD. 20832</b>								
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. [Signature]</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11236

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James E. Kelly				2. DATE OF DEATH MONTH DAY YEAR March 22, 1995				3. TIME OF DEATH 10:45 P M		
4. SOCIAL SECURITY NUMBER 577-54-0636		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1923		8. BIRTHPLACE (State or Foreign Country) Kentucky				
9a. FACILITY NAME (If not Institution, give street and number) 5004 Benton Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda			9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5004 Benton Avenue				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) — College (1-4 or 5+) 5+		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dental Director			16b. KIND OF BUSINESS/INDUSTRY Public Health Service					
17. FATHER'S NAME (First, Middle, Last) Ernest Kelly				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alpha Lile						
19a. INFORMANT'S NAME (Type/Print) Helen G. Kelly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5004 Benton Avenue, Bethesda, Maryland 20814						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. March 24, 1995			20c. LOCATION — City or Town, State Bethesda, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa P. Kutto</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, MD 20814-3501						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death		
a. Hepatic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):										
b. Liver Cirrhosis DUE TO (OR AS A CONSEQUENCE OF):										
c. DUE TO (OR AS A CONSEQUENCE OF):										
d. DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Janet M. Nicolas, M.D.</i> MD				29c. LICENSE NUMBER 0101051315 (VA)			29d. DATE SIGNED (Month, Day, Year) March 23, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Janet M. Nicolas, M.D., National Naval Medical Center Bethesda, MD 20889										
31. DATE FILED (Month, Day, Year) MAR 27 1995				32. REGISTRAR'S SIGNATURE <i>John A. Wilson-Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #1 per FH 3/29/95 Montgomery County 95 11237  
 FOR  
 1 - STATE  
 REGISTRAR  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSEMARY JANE KINLEY</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0340</b> M	
4. SOCIAL SECURITY NUMBER <b>472-24-7875</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 23, 1928</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		10. COUNTY OF DEATH <b>Montgomery</b>	
11. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Montgomery</b> 10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b> 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				12. STREET AND NUMBER <b>10000 Dellcastle Road</b>			
13. 101. ZIP CODE <b>20879</b>				14. 10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
15. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		18. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
19. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-</b> College (1-4 or 5+) <b>2</b>		20. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Store Proprietor</b>		21. 16b. KIND OF BUSINESS/INDUSTRY <b>Antiques</b>			
22. 17. FATHER'S NAME (First, Middle, Last) <b>Harry Arthur Wagner</b>				23. 18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Esther Cora Johnson</b>			
24. 19a. INFORMANT'S NAME (Type/Print) <b>Lee Allen Nienaber</b>				25. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12118 Flag Harbor Drive, Germantown, MD 20874</b>			
26. 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		27. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>March 29, 1995</b> <b>Montgomery Crematorium, Inc.</b>		28. 20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>			
29. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michelle P. Kutto</b> M00348				30. 22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805</b>			
31. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Small bowel obstruction</b> Approximate Interval Between Onset and Death <b>1 mo.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Metastatic Pancreatic CA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>&gt;1 yr.</b> c. <b>Rectal fistula</b> DUE TO (OR AS A CONSEQUENCE OF): <b>1 mo.</b> d. <b>Alcoholic Liver disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>&gt;1 yr.</b>							
32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure</b> <b>Anemia</b>							
33. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				34. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
35. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
36. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		37. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
38. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		39. 28a. DATE OF INJURY (Month, Day, Year)		40. 28b. TIME OF INJURY <b>M</b>		41. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
42. 28d. DESCRIBE HOW INJURY OCCURRED				43. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
44. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
45. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
46. 29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Sudhakar M</b>				47. 29c. LICENSE NUMBER <b>D35792</b>		48. 29d. DATE SIGNED (Month, Day, Year) <b>MARCH 27 1995</b>	
49. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SWAROOP SUDHAKAR, 50. W. EDMONSTON DR, R. MD. 20850</b>							
50. 31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>		51. 32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11238

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIE H. KEHR</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>27</b> YEAR <b>95</b>		3. TIME OF DEATH <b>0105 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-40-3439</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 10, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>N/A</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Washington, D.C.</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STREET AND NUMBER <b>115 Carroll Street, N.W.</b>				10f. ZIP CODE <b>20012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joel R. Dean</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alma E. Persons</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lenore Phillips</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Carroll Street, N.W., Washington, D.C. 20012</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		DATE <b>3/29</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alma E. Persons</i>				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>DIVERTICULITIS</b>							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Kelman MD</i>				29c. LICENSE NUMBER <b>D20391</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEFFREY KELMAN, 6525 BELLEVIEW ROAD, HYATTSVILLE, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Roberts</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11239

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Ann Kelly</i>				2. DATE OF DEATH MONTH <i>MARCH</i> DAY <i>27</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>755 p. m.</i>	
4. SOCIAL SECURITY NUMBER <i>506-64-3300</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>57</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Mar. 9, 1938</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Laurel Regional Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Laurel</i>		9c. COUNTY OF DEATH <i>Prince Georges</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince Georges</i>		10c. CITY, TOWN OR LOCATION <i>Laurel</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>801 Kay Court</i>				10f. ZIP CODE <i>20707</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>None</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Marvin Watkins</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Katherine Lewis</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Norman E. Kelly (Husband)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>801 Kay Court, Laurel, MD 20707</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>MD. Nat'l Mem. Park</i>		DATE <i>4/3</i>		20c. LOCATION — City or Town, State <i>Laurel, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <i>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i></i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <i>4 days</i> <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin dependent diabetes mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>T. J. Kim MD</i>				29c. LICENSE NUMBER <i>D 33979</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>THEODORE Kim, MD. 4000 Mitchell Rd Bowie, MD 20716</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 30 1995</i>				32. REGISTRAR'S SIGNATURE <i>Jahia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11240

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Zaitun Kamaludin				2. DATE OF DEATH MONTH March DAY 26 YEAR 1995				3. TIME OF DEATH 9:15 AM			
4. SOCIAL SECURITY NUMBER 212-96-9550				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) 8750 Georgia Avenue, # 703B				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Silver Spring			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 8750 Georgia Ave., #703B				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? USA Permanent Resident	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Indian				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13-16) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			
16b. KIND OF BUSINESS/INDUSTRY Own Home				17. FATHER'S NAME (First, Middle, Last) Sheik Ali-John				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bibi Islemen			
19a. INFORMANT'S NAME (Type/Print) Mohamed Shaffee Deen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Fallsmead Way, Rockville, Maryland 20854							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 3/28				20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Seizure Disorder DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension Approximate Interval Between Onset and Death 3 yrs 6 months 5 yrs 7 yrs											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D32817				29d. DATE SIGNED (Month, Day, Year) 3/26/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Waheed Khan MD 12016 Georgia Ave, Silver Spring MD 20902											
31. DATE FILED (Month, Day, Year) MAR 30 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ramona A. Lloveras</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>1</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>4:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>079-24-3683</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 30, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Puerto Rico</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Camp Spring</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1145 B. Dawson Ct.</b>				10f. ZIP CODE <b>20335</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Puerto Rican</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Printing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Braulio ROSARIO Colon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ramona Santos Luiggi</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Angel A. Bouet</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1145 B. Dawson Ct. Camp Springs, Md. 20335</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>San Juan Municipal Cemetery April 5, 1995</b>				20c. LOCATION — City or Town, State <b>San Juan Puerto Rico</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL ISCHEMIA</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>ARRHYTHMIA</b> c. <b></b> d. <b></b>								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>22150V</b>		29d. DATE SIGNED (Month, Day, Year) <b>APR 4 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BERTSALAN H FINDER, MD 7501 SUBBATT RD CLINTON MD 20735</b>									
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11242

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lars Larson</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>23</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>5:03P<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>091-10-1617</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7. DATE OF BIRTH (Month, Day, Year) <b>9-16-1908</b>				8. BIRTHPLACE (State or Foreign Country) <b>SWEDEN</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Wicomico Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>				9c. COUNTY OF DEATH <b>Wicomico</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>305 LEMMON HILL LANE</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PHYSICAL THERAPIST</b>				16b. KIND OF BUSINESS/INDUSTRY <b>MEDICINE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>KARL LARSON</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HILNA LARSON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>INGRID BRUNET</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 LEMMON HILL LANE, SALISBURY, MD. 21801</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WINTHROP CITY VAULT</b>		DATE <b>3-27</b>		20c. LOCATION — City or Town, State <b>WINTHROP, MAINE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott L. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepato Renal Failure.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Diffuse Metastasis</b> c. <b>Small Cell Ca of Lung -</b>								Approximate Interval Between Onset and Death <b>1m</b> <b>?</b> <b>175</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diffuse Arteriosclerosis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. [Signature]</i>				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 24, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.G. Arthes MD 1622A Ocean Pines, Berlin, Md. 21811</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

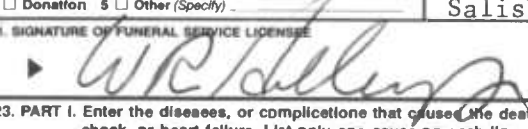

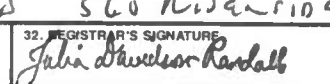
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11243

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN ELIZABETH LEHMAN				2. DATE OF DEATH MONTH 3 DAY 21 YEAR 85		3. TIME OF DEATH 6:35 A M	
4. SOCIAL SECURITY NUMBER 130-18-6217		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 16, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER John B. Parsons Home, 300 Lemmon Hill	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) William Henry Schaeffer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Burke			
19a. INFORMANT'S NAME (Type/Print) Virginia E. Lehman Mitchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Edgewater Dr., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State 3/22 Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CHF</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>CVA</u> Approximate Interval Between Onset and Death 20 MIN. 2 YRS.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u> <u>HTN</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29168		29d. DATE SIGNED (Month, Day, Year) 3/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT ALLEN 560 WILSON RD SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) MAR 22 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11244

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH MABEL Long</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0217</b> M	
4. SOCIAL SECURITY NUMBER <b>218-24-6019</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 13 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Princess Anne</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>30441 Oak Street</b>				10f. ZIP CODE <b>21853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Housewife</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Andrew Hooks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Ogburn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda K. Holsinger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1409 Westchester Drive, Salisbury, Md. 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Beechwood Cemetery</b>		DATE <b>4/1</b>		20c. LOCATION — City or Town, State <b>Princess Anne, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Hines</i> M00294				22. NAME AND ADDRESS OF FACILITY <b>Hinman Funeral Home Princess Anne, Md. 21853</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Cardiomyopathy</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey E. Herton</i>				29c. LICENSE NUMBER <b>D36783</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/29/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey E. Herton, MD. PRMC SALISBURY, MD. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1947-1948

95 11245

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret N. LEAR</i>				2. DATE OF DEATH MONTH DAY YEAR <i>APRIL 1st 1995</i>		3. TIME OF DEATH <i>2:05 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-34-9598</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 2, 1910</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Howard</i>		10c. CITY, TOWN OR LOCATION <i>Clarksville</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>11462 Old Hopkins Road</i>				10f. ZIP CODE <i>21029</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Thomas Guy Nichols</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret Hewitt</i>			
19a. INFORMANT'S NAME (Type/Print) <i>George M. Lear</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11462 Old Hopkins Rd., Clarksville, Md. 21029</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Louis</i>		20c. DATE <i>4/5/95</i>		20d. LOCATION — City or Town, State <i>Clarksville, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stanley Lowener</i>				22. NAME AND ADDRESS OF FACILITY <i>HARRY H. WITZKE FUNERAL HOME 4112 Old Columbia Pike, Ellicott City 21043</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Bronchopneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i>Stroke</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerotic Cardiovascular Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY H		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N.B. Vellanki MD</i>				29c. LICENSE NUMBER <i>D-30469</i>		29d. DATE SIGNED (Month, Day, Year) <i>APR 1st 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>N.B. VELLANKI MD, 9055, CHEVROLET DRIVE, #100, ELICOTT CITY MD 21042</i>							
31. DATE FILED (Month, Day, Year) <i>APR 04 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11246

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Timothy Aloysius Lynch, S.T.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:10 PM</b>	
4. SOCIAL SECURITY NUMBER <b>249-02-1833</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 15, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>				9. COUNTY OF DEATH <b>Montgomery</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Adelphi</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1733 Metzertott Road</b>				10f. ZIP CODE <b>20783</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Priest</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Religious</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Francis Lynch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Kelly</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rev. Robert Shay</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1733 Metzertott Road Adelphi, Maryland 20783</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Trinity Cemetery 4/4/95</b>		20c. LOCATION — City or Town, State <b>Fort Mitchell, Alabama</b>		20d. DATE <b>4/4/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Andrew J. Cole</b>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ELECTROLYTE ABNORMALITY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>UREMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>DEHYDRATION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>SEPSIS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Walter E. Goetz</b>				29c. LICENSE NUMBER <b>D01120</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WALTER E. GOETZ MD 2307 SHOREFIELD ROAD WHEATON MD 20902</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE <b>John D. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11247

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roman Lucyk				2. DATE OF DEATH MONTH DAY YEAR March 25, 1995				3. TIME OF DEATH 5:10 P. M.					
4. SOCIAL SECURITY NUMBER 329-28-3948		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7. DATE OF BIRTH (Month, Day, Year) MAY 21, 1904				8. BIRTHPLACE (State or Foreign Country) UKRAINE									
9a. FACILITY NAME (If not institution, give street and number) 5301 Westbard Circle #330				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Bethesda					
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
10e. STREET AND NUMBER 5301 Westbard Circle #330				10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					
14. RACE — American Indian, Black, White, etc. Specify: WHITE													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRAFTSMAN				16b. KIND OF BUSINESS/INDUSTRY MANUFACTURING					
17. FATHER'S NAME (First, Middle, Last) SEWERYN LUCYK				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIA PLASZOWECKA									
19a. INFORMANT'S NAME (Type/Print) ALEXANDRA LUCYK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301 WESTBARD CIRCLE, BETHESDA, MD. 20816									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY				DATE 3/29		20c. LOCATION — City or Town, State SUITLAND, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, DC 20016									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC ADENOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): PULMONARY ADENOCARCINOMA b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 YEARS 5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIA HEART DISEASE OSTEOARTHRITES DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vernon Simmons</i>				29c. LICENSE NUMBER 2145		29d. DATE SIGNED (Month, Day, Year) MARCH 27, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert F. Dyer, M.D. 5530 Wisconsin Avenue Suite 540 Chevy Chase, Maryland 20815													
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11248

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel B. Lake				2. DATE OF DEATH MONTH DAY YEAR March 24 1995				3. TIME OF DEATH 7:10 A M		
4. SOCIAL SECURITY NUMBER 264-02-5147		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 1, 1901		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.		
9a. FACILITY NAME (If not institution, give street and number) Springbrook Adventist Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring			9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Jessup			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 8118 Sheffield Court				10f. ZIP CODE 20794		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Charles Bartelmes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Smoot						
19a. INFORMANT'S NAME (Type/Print) Paul A. Lake				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8118 Sheffield Court, Jessup, Maryland 20794						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 3/28			DATE 3/28		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John D. Knald</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>1 week</i>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Senile Dementia</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. ...</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 27, 95</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. ... 8218 W. ... Ave</i>										
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11249

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DONALD RAY MAYSE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 31, 1995</b>		3. TIME OF DEATH <b>1:47A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-62-5802</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>41</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>June 7, 1953</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>V.A. Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Perry Point</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Conowingo</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1063 Dr. Jack Road</b>				10f. ZIP CODE <b>21918</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1970 - 1972</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>Ten Years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Wireman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Army</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Tavis Mayse</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mullins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Tavis Mayse</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1063 Dr. Jack Road, Conowingo, Maryland 21918</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Bridge Baptist Church Cemetery 4/3/95</b>		20c. LOCATION — City or Town, State <b>Rising Sun, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas M. Patterson, Sr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatic Encephalopathy</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Prasad Nataraj, M.D.</i>				29c. LICENSE NUMBER <b>L09315R</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-31-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Prasad Nataraj, M.D. VA Medical Center Perry Point, Perry Point, MD 21902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11250

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES DAVID MCNEAL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 29, 1995</b>		3. TIME OF DEATH <b>12:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>417-32-2654</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 21, 1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3734 Washington Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Abingdon</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Abingdon</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3734 Washington Ave.</b>				10f. ZIP CODE <b>21009</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Motion Picture Production Specialist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Walton McNeal</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vitina (nm) Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anne H. McNeal</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3734 Washington Ave., Abingdon, Md. 21009</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rock Run Cemetery</b>		DATE <b>4/1/95</b>		20c. LOCATION — City or Town, State <b>Havre de Grace, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas</i>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CIRRHOSIS</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholism</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>ROY H. PHILLIPS, M.D.</b>				29c. LICENSE NUMBER <b>0022843</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If item 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.)							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


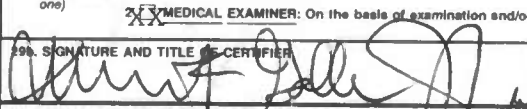
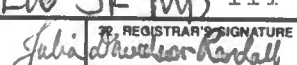


Amended Item # 27 4/4/95 c.c. S. Campbell

95 11251

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LINDA LEE MORRISON</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>03</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:45A</b>	
4. SOCIAL SECURITY NUMBER <b>220-28-7999</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 29, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH <b>CARROLL COUNTY</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>TANEYTOWN</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10 COMMERCE ST.</b>			
10f. ZIP CODE <b>21787</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>CAUCASIAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ARTHUR CLAY LOWMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA AMELIA WINEMILLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLYNN MORRISON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 COMMERCE ST. TANEYTOWN, MARYLAND 21787</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SMITHSBURG CREMATORY</b>		20c. LOCATION — City or Town, State <b>4-4 SMITHSBURG, MARYLAND</b>		20d. DATE <b>4-4</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SKILES FUNERAL HOME 136 E. BALTIMORE ST. TANEYTOWN, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RUPTURED AORTIC ANEURYSM</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 04/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIA F. GOLIS JR MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11252

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ada Estella Matthews</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 28, 1995</b>				3. TIME OF DEATH <b>0745A</b> M	
4. SOCIAL SECURITY NUMBER <b>230-52-7314</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 16, 1941</b>		8. BIRTHPLACE (State or Foreign Country) <b>VA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4461 Allen Road</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housekeeping</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Holiday Inn (Hotel)</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clifton Matthews, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Burton</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Goldsboro Milbourne</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4461 Allend Road - Salisbury, MD 21801</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Acres Memorial Park 3/25 Salisbury, MD</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell J. Forke</i>				22. NAME AND ADDRESS OF FACILITY <b>Fooks Funeral Service 917 W. Isabella Street - Salisbury, MD</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>MASSIVE LEFT CEREBRAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF): c. d. Approximate Interval Between Onset and Death <b>5 DAYS</b> <b>9 DAYS</b> <b>4 YEARS</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MORBID OBESITY</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard E. Bird MD</i>							
		29c. LICENSE NUMBER <b>D-22132</b>				29d. DATE SIGNED (Month, Day, Year) <b>3-22-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RICHARD E. BIRD MD 560 RIVERSIDE DR, SALISBURY, MD 21801</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11253

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN T. MAJORS, Jr.</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>24</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>0600</b> M	
4. SOCIAL SECURITY NUMBER <b>218-20-7525</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <b>10/3/1927</b>				8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>					
9a. FACILITY NAME (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Princess Anne</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11974 Edgehill Terrace</b>				10f. ZIP CODE <b>21853</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army W.W.2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>				16b. KIND OF BUSINESS/INDUSTRY <b>House Painter</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John T. Majors, Sr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Majors</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Alice Taylor Barnette</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1021 Pierce Ave, Salisbury, Md. 21801</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Athol Baptist Cem. 3/26</b>		20c. LOCATION — City or Town, State <b>Mardela, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MOO-417				22. NAME AND ADDRESS OF FACILITY <b>Messick Funeral Home, P.O. Box 61 Bivalve, Md. 21814</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MASSIVE @ CATHETER ARTERY BLEEDING</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>FAR ADVANCED CANCER OF @ TONSIL &amp; BASE OF TONGUE</b>  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>4 days</b> <b>1 yr.</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Charles Schaefer</i>				29c. LICENSE NUMBER <b>D 13191</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-24-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>560 B102 RIVERSIDE DR. SALISBURY MD. 21801</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

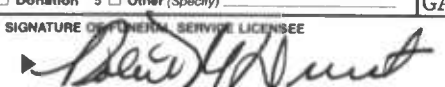

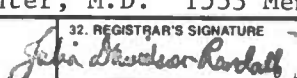




95 11254

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES GORDON McROBIE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>3</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-7666</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 4, 1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>	
9c. COUNTY OF DEATH <b>GARRETT</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>	
10c. CITY, TOWN OR LOCATION <b>MT. LAKE PARK</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>612 "K" STREET</b>	
10f. ZIP CODE <b>21550</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COMPUTER SPECIALIST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GORDON DRYDON McROBIE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ELIZABETH MILLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>NINA F. McROBIE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 "K" STREET MT. LAKE PARK, MD 21550</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRETT MEMORIAL GARDENS 4/5</b>		20c. LOCATION — City or Town, State <b>OAKLAND, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD. 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cholangiocarcinoma of the liver</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Cholangiocarcinoma of the liver</b> b. <b>Hemochromatosis</b> c. <b>Cirrhosis</b> d. <b>Cirrhosis</b> Approximate interval Between Onset and Death <b>9 mo</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30035</b>		29d. DATE SIGNED (Month, Day, Year) <b>04-03-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>APR 4 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11255

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>MEADOWS JAMES</i> JAMES EDWARD MEADOWS				2. DATE OF DEATH MONTH DAY YEAR MARCH 28, 1995		3. TIME OF DEATH 2:09 P M	
4. SOCIAL SECURITY NUMBER 218-14-4720		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV 5, 1922	
8. BIRTHPLACE (State or Foreign Country) W. VA.				9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND	
9c. COUNTY OF DEATH GARRETT				10a. STATE MARYLAND		10b. COUNTY GARRETT	
10c. CITY, TOWN OR LOCATION OAKLAND				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 159 OLD CRELLIN ROAD	
10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8 Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR		16b. KIND OF BUSINESS/INDUSTRY CHICKEN PROCESSING	
17. FATHER'S NAME (First, Middle, Last) LESTER PAUL MEADOWS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE (unknown)			
19a. INFORMANT'S NAME (Type/Print) FREDA MEADOWS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 OLD CRELLIN ROAD OAKLAND, MD 21550			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OMEGA CREMATORY 4/1		20c. LOCATION — City or Town, State MORGANTOWN, W. VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MO0167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION 10 min Due to (or as a consequence of): b. METASTATIC COLONIC CARCINOMA ~2 wks Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Xus Due to (or as a consequence of): d. DIABETES MELLITUS Xus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PRIOR MYOCARDIAL INFARCTION CHRONIC ALCOHOLISM DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER MD.D29313		29d. DATE SIGNED (Month, Day, Year) 3/30/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 311 N 4A ST. OAKLAND MD 21550							
31. DATE FILED (Month, Day, Year) APR 3 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A# 8206927



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

K



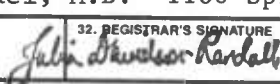
<b>1. DECEDENT'S NAME</b> (First, Middle, Last) <b>Myrtle Evelyn Mersing</b>				<b>2. DATE OF DEATH</b> MONTH DAY YEAR <b>March 24, 1995</b>		<b>3. TIME OF DEATH</b> <b>10:55 P M</b>	
<b>4. SOCIAL SECURITY NUMBER</b> <b>213-74-3061</b>		<b>5. SEX</b> 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	<b>6. AGE</b> (In yrs. last birthday) <b>90 YRS.</b>	<b>IF UNDER 1 YEAR</b> MONTHS DAYS HOURS MIN. 		<b>IF UNDER 24 HRS.</b> HOURS MIN. 	
<b>7a. FACILITY NAME</b> (If not institution, give street end number) <b>Garrett County Memorial Hospital</b>				<b>7b. CITY, TOWN OR LOCATION OF DEATH</b> <b>Oakland</b>		<b>7c. COUNTY OF DEATH</b> <b>Maryland</b>	
<b>RESIDENCE OF DECEDENT</b>							
<b>10a. STATE</b> <b>WV</b>		<b>10b. COUNTY</b> <b>Preston</b>		<b>10c. CITY, TOWN OR LOCATION</b> <b>Corinth</b>		<b>10d. INSIDE CITY LIMITS?</b> 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
<b>10e. STREET AND NUMBER</b> <b>HC 65, Box 123</b>				<b>10f. ZIP CODE</b> <b>26764</b>		<b>10g. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>11. MARITAL STATUS</b> 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		<b>12. WAS DECEDENT EVER IN U.S. ARMED FORCES?</b> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		<b>13. WAS DECEDENT OF HISPANIC ORIGIN?</b> (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		<b>14. RACE — American Indian, Black, White, etc.</b> Specify: <b>White</b>	
<b>15. DECEDENT'S EDUCATION</b> (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>7</b>		<b>16a. DECEDENT'S USUAL OCCUPATION</b> (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		<b>16b. KIND OF BUSINESS/INDUSTRY</b> <b>Home</b>			
<b>17. FATHER'S NAME</b> (First, Middle, Last) <b>Charles W. Nine</b>				<b>18. MOTHER'S NAME</b> (First, Middle, Maiden Surname) <b>Sarah ----- Long</b>			
<b>19a. INFORMANT'S NAME</b> (Type/Print) <b>Sara R. Mersing</b>				<b>19b. MAILING ADDRESS</b> (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC 65, Box 123, Corinth, West Virginia 26764</b>			
<b>20a. METHOD OF DISPOSITION</b> 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		<b>20b. PLACE AND DATE OF DISPOSITION</b> (Name of cemetery, crematory or other place) <b>Garrett Co. Mem. Gardens</b>		<b>DATE</b> <b>3/27</b>		<b>20c. LOCATION — City or Town, State</b> <b>Oakland, Maryland</b>	
<b>21. SIGNATURE OF FUNERAL SERVICE LICENSEE</b> 				<b>22. NAME AND ADDRESS OF FACILITY</b> <b>Stewart Funeral Home</b> <b>32 S. Second St., Oakland, MD 21550</b>			
<b>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</b>						<b>Approximate Interval Between Onset and Death</b>	
<b>IMMEDIATE CAUSE</b> (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b>						<b>1 hr.</b>	
<b>b. OUE TO (OR AS A CONSEQUENCE OF):</b>							
<b>c. OUE TO (OR AS A CONSEQUENCE OF):</b>							
<b>d. OUE TO (OR AS A CONSEQUENCE OF):</b>							
<b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>							
<b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b>							
<b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
<b>25. WAS CASE REFERRED TO MEDICAL EXAMINER?</b> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		<b>26. PLACE OF DEATH</b> (Check only one) <b>HOSPITAL:</b> 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA <b>OTHER:</b> 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
<b>27. MANNER OF DEATH</b> 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> 4 <input type="checkbox"/> Homicide		<b>28a. DATE OF INJURY</b> (Month, Day, Year)		<b>28b. TIME OF INJURY</b> <b>M</b>		<b>28c. INJURY AT WORK?</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
<b>28d. DESCRIBE HOW INJURY OCCURRED</b>				<b>28f. LOCATION</b> (Street and Number or Rural Route Number, City or Town, State)			
<b>29a. CERTIFIER</b> 1 <input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
<b>29b. SIGNATURE AND TITLE OF CERTIFIER</b>  <b>MD</b>				<b>29c. LICENSE NUMBER</b> <b>D27205</b>		<b>29d. DATE SIGNED</b> (Month, Day, Year) <b>3/24/95</b>	
<b>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)</b> (Type, Print) <b>Karl E. Schwalm 311 N. 4th St., Oakland, MD 21550</b>							
<b>31. DATE FILED</b> (Month, Day, Year) <b>MAR 30 1995</b>		<b>32. REGISTRAR'S SIGNATURE</b> 					



95 11257

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Joseph Donald Moyer				2. DATE OF DEATH MONTH DAY YEAR March 29 1995		3. TIME OF DEATH 2:30 P M	
4. SOCIAL SECURITY NUMBER 175-14-5600		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 15, 1920	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 10707 Francis Drive		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10707 Francis Drive	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, DIVE WAR OR DATES 1942-1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chemist		16b. KIND OF BUSINESS/INDUSTRY Research	
17. FATHER'S NAME (First, Middle, Last) Earl H. Moyer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane Ann Greaves			
19a. INFORMANT'S NAME (Type/Print) Lynette R. Moyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10707 Francis Drive Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Ridge Memorial Park 4/3/95		20c. LOCATION — City or Town, State Pennsville, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Congestive Heart Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Cardiomyopathy							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D 43414		29d. DATE SIGNED (Month, Day, Year) March 30, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert G. Finkel, M.D. 1106 Spring Street Silver Spring, Maryland 20910							
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



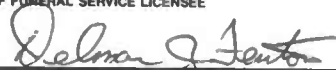
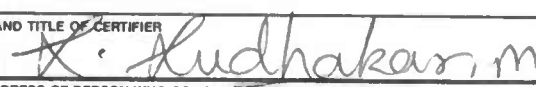
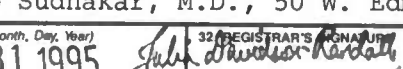


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH REG. NO.

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last) <b>Mildred McLarney</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 28, 1995</b>				3. TIME OF DEATH <b>10:20 P M</b>									
4. SOCIAL SECURITY NUMBER <b>319-40-0113</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 3, 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Illinois</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Nursing Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>				9c. COUNTY OF DEATH <b>Montgomery</b>							
10a. STATE <b>Maryland</b>												10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9701 Medical Center Drive</b>						10f. ZIP CODE <b>20850</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Florist</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Flower Shop</b>									
17. FATHER'S NAME (First, Middle, Last) <b>John Leshyn</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alexandra Swerski</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Kathleen Thies</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10310 Cutters Lane Potomac, Maryland 20854</b>													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resurrection Cemetery March 30, 1995</b>				20c. LOCATION — City or Town, State <b>Justice, Illinois</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00202</b>				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> e. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>48 Hours</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>&gt; 1 Year</b> c. <b>Stroke</b> DUE TO (OR AS A CONSEQUENCE OF): <b>&gt; 1 Year</b> d. <b>Atrial Fibrillation</b> <b>&gt; 1 Year</b>																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Depression</b>																	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dr. Swaroop Sudhakar, MD</b>						29c. LICENSE NUMBER <b>D 35792</b>				29d. DATE SIGNED (Month, Day, Year) <b>March 29, 1995</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Swaroop Sudhakar, M.D., 50 W. Edmonston Drive, Rockville, Maryland 20852</b>																	
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE 													



95 11259

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Nancy J. McVicker</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MARCH 24 1995</i>		3. TIME OF DEATH <i>10:00 P M</i>	
4. SOCIAL SECURITY NUMBER <i>058-32-4971</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>59</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 18, 1935</i>	
8. BIRTHPLACE (State or Foreign Country) <i>New York</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Rockville</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>14208 Oakvale Street</i>	
10f. ZIP CODE <i>20853</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nurse</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Adventist Home Health Services</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Guy Moscate</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Stewart</i>			
19a. INFORMANT'S NAME (Type/Print) <i>William McVicker</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>14208 Oakvale Street, Rockville, Maryland 20853</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 3/25</i>		20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lini Brent Holland</i>				22. NAME AND ADDRESS OF FACILITY <i>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory Failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>b. Metastatic Breast Cancer</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>c.</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>d.</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bone metastases</i> <i>malignant Acites</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lini Brent Holland MD</i>				29c. LICENSE NUMBER <i>D 21910</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 22, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 27 1995</i>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Karall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11260

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER WAGNER McKAY				2. DATE OF DEATH MONTH DAY YEAR March 23, 1995		3. TIME OF DEATH 9:42 P M	
4. SOCIAL SECURITY NUMBER 578-30-1647		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 11, 1908	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring,		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9413 Seminole Street				10f. ZIP CODE 20901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Self			
17. FATHER'S NAME (First, Middle, Last) Benjamin F. Ashby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Wagner			
19a. INFORMANT'S NAME (Type/Print) Esther E. Hubbard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9413 Seminole St., Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cem., 3-27-95		20c. LOCATION — City or Town, State Adelphi, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas Gueon</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. DUE TO (OR AS A CONSEQUENCE OF): SEPSIS							
b. DUE TO (OR AS A CONSEQUENCE OF): Urinary tract infection							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Chahw...</i>				29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) 3/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mohammad A Khalil 1299 - Lambert Dr SE Silver Spring MD 20902							
31. DATE FILED (Month, Day, Year) MAR 27 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11261

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Abhimanyu Mehrotra</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1995</b>		3. TIME OF DEATH <b>12:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-96-7006</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 11, 1914</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		10. COUNTY OF DEATH <b>Montgomery</b>	
11. STATE <b>Maryland</b>				12. COUNTY <b>Montgomery</b>		13. CITY, TOWN OR LOCATION <b>Potomac</b>	
14. STREET AND NUMBER <b>9204 Sprinklewood Lane</b>				15. ZIP CODE <b>20854</b>		16. CITIZEN OF WHAT COUNTRY? <b>India</b>	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Superintendent</b>		23. KIND OF BUSINESS/INDUSTRY	
24. FATHER'S NAME (First, Middle, Last) <b>Salig Ram Mehrotra</b>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vindh D. Tandon</b>			
26. INFORMANT'S NAME (Type/Print) <b>Prafulla P. Mehrotra</b>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9204 Sprinklewood Ln., Potomac, Md. 20854</b>			
28. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Northern Va. Crematory 3/18/95</b>		30. DATE <b>3/18/95</b>		31. LOCATION — City or Town, State <b>Arl., Va.</b>	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE 				33. NAME AND ADDRESS OF FACILITY <b>Arlington Funeral Home 3901 N. Fairfax Dr., Arl., Va. 22203</b>			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Subdural Hematoma</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Fall</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic Prostate Cancer</b>							
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				37. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
39. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		40. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
41. 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		42. 28a. DATE OF INJURY (Month, Day, Year) <b>3/14/95</b>		43. 28b. TIME OF INJURY <b>A M</b>		44. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		45. 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		46. 28e. DESCRIBE HOW INJURY OCCURRED <b>Fell Down Steps</b>			
		47. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>#10</b>					
48. 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
49. 29b. SIGNATURE AND TITLE OF CERTIFIER 				50. 29c. LICENSE NUMBER <b>DO 7094</b>		51. 29d. DATE SIGNED (Month, Day, Year) <b>MARCH 17 1995</b>	
52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Francis C. Mayle 10215 Fernwood Rd., Bethesda, Md. 20817</b>							
53. 31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				54. 32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11262

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Cecelia May Mooney</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 25, 1995</b>				3. TIME OF DEATH <b>1:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-01-2884</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>May 11, 1911</b>		7. DATE OF BIRTH (Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number) <b>1600 Woodwell Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1600 Woodwell Road</b>				10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Telephone Operator Supervisor Telephone</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Grover C. Herbert</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary E. Gatton</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Suzanne Lee Morrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1600 Woodwell Road Silver Spring, Maryland 20906</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 3/28/95</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple Strokes</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>5 months</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martha Spencer Saavedra</i>				29c. LICENSE NUMBER <b>D 41173</b>				29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Martha Spencer Saavedra, M.D. 3701 International Drive Silver Spring, MD 20906</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

35

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11263

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY A. NAVAZIO</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>2</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:05 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>098-32-6910</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 7, 1905</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6336 Cedar Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6336 Cedar Lane</b>				10f. ZIP CODE <b>21044</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Carmelo Atonna</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beatrice Scalera</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael Naver</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Helms Pick Court, Catonsville, Md. 21228</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Washington Apr. 5 95</b>		20c. LOCATION — City or Town, State <b>Laurel, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stanley Loewner</i>				22. NAME AND ADDRESS OF FACILITY <b>HARRY H. WITZKE FUNERAL HOME 4112 Old Columbia Pike, Ellicott City 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death <b>6 days</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Acute pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 wks</b>	
		c. <b>Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>8 yrs</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic gastritis</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jon K. Minford</i>				29c. LICENSE NUMBER <b>030573</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-4-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2 Knoll N. Dr. Columbia Md. 21045 Jon K. Minford, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3


TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

95 11264

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTHER NUSINOVICH</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-35-0485</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 19, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ukraine</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Collingswood Nursing Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>299 Hurley Avenue</b>	
10f. ZIP CODE <b>20850</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (14 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Physics Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Isaac Burdo</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gitel Katz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alexander Nusinovich (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11812 Silent Valley Lane, N. Potomac, Md. 20878</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. Lebanon 3-26</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Md. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Glioma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerosis Cardiovascular Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Myron L. Lenkin</b>				29c. LICENSE NUMBER <b>D06674</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/25/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MYRON L. LENKIN MD 2309 SHOREFIELD ROAD WHEATON MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11265

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA EDNA OWENS</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:05 p m</b>	
4. SOCIAL SECURITY NUMBER <b>220 - 28 - 6694</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar 19, 1933</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>308 Sandy Spring Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>		9c. COUNTY OF DEATH <b>Prince George</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Laurel</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>308 Sandy Spring Road</b>				10f. ZIP CODE <b>20707</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade 12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Databank Clerk</b>		15b. KIND OF BUSINESS/INDUSTRY <b>United States Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Maynard Eugene Sherman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Farell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jill Owens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8725 Cardinal Forest Circle, Laurel, MD 20723</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 3/31</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARCINOMA LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>NEURONAL FIBROSIS</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>5 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D19220</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-29-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Neil A Meade 4811 Mallard Drive Laurel Md 20708</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHANDLER

1873

1873

1873

1873

1873



95 11266

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY JEAN PITTMAN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8:05 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>288 28 5548</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03/03/33</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>				9a. FACILITY NAME (If not institution, give street and number) <b>50 Highland Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>	
9c. COUNTY OF DEATH <b>Cecil</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>	
10c. CITY, TOWN OR LOCATION <b>Elkton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>50 Highland Avenue</b>	
10f. ZIP CODE <b>21921</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Clerk</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Sears Roebuck Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Logan Schultz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Blazer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Paul W. Pittman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>50 Highland Ave., Elkton, Md. 21921</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Immaculate Conception Cem. Cherry Hill, Md.</b>		20c. LOCATION — City or Town, State <b>Cherry Hill, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Gee Funeral Home 259 E. Main St., Elkton, Md. 21921</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Small Cell Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Well Differentiated Non-Hodgkin's Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic Lymphocytic Leukemia</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D06181</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/28/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type name) <b>Joseph G. Lanzi, M.D. 721 N. Bridge St. Elkton, MD 21921</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11267

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SIDNEY POWELL</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>31</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>235-26-0060</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 18, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9. FACILITY NAME (If not institution, give street and number) <b>CITIZENS NURSING HOME</b>			
10. STATE <b>Maryland</b>				10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1532 Glenville Road</b>			
10f. ZIP CODE <b>21078</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Farming</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Orvel Powell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Erma Marie Hayes</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Cardor Ct. Baltimore, Maryland 21236</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc. 4/3</b>		20c. LOCATION — City or Town, State <b>West Chester, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harry R. Di Giovanni</b>				22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Cardio Pulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Atherosclerosis</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>T. BRONDO del</b>				29c. LICENSE NUMBER <b>012800</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>T. BRONDO del, Unit 319 S. Union Ave, #1018, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>		32. REGISTRAR'S SIGNATURE <b>Fabia Anderson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELLA MARIE PURNELL				2. DATE OF DEATH MONTH DAY YEAR MARCH 18 1995		3. TIME OF DEATH 6:10 P <sup>M</sup>	
4. SOCIAL SECURITY NUMBER 214-60-7727		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6 26 55	
8. BIRTHPLACE (State or Foreign Country) NEWARK, MD.				9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BERLIN	
9c. COUNTY OF DEATH WORCESTER				10a. STATE MD.		10b. COUNTY WORCESTER	
10c. CITY, TOWN OR LOCATION BERLIN				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 10122 PIN OAK DRIVE	
10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES.	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 <sup>th</sup> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC	
16b. KIND OF BUSINESS/INDUSTRY HOUSEMAID		17. FATHER'S NAME (First, Middle, Last) CARL PURNELL		18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE FOREMAN		19a. INFORMANT'S NAME (Type/Print) INDIA DALE	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE		20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WILLIAMS ABE CHURCH CE 3-25		20c. LOCATION — City or Town, State NEWARK, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i>		22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cirrhosis of the liver</i>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerosis of the coronary arteries</i> <i>history of asthma</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MARCH 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAR 22 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



95 11269

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lurane L. Patterson</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>24</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>12:40 A M</u>	
4. SOCIAL SECURITY NUMBER <u>579-26-9672</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <u>86</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 5, 1908</u>	
8a. FACILITY NAME (If not institution, give street and number) <u>Holy Cross Hospital</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u>		8c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Silver Spring</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>10202 Duvawn Place</u>				10f. ZIP CODE <u>20902</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Constantine Lynard</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ginoula Dounis</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Katherine Patterson</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10202 Duvawn Place Silver Spring, Md. 20902</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Ft. Lincoln Cemetery 3/27/95</u>		20c. LOCATION — City or Town, State <u>Brentwood, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave. Silver Spring</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory failure</u> Due to (or as a consequence of): <u>Chronic Obstructive Pulmonary Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Respiratory failure</u> b. <u>Chronic Obstructive Pulmonary Disease</u> c. <u></u> d. <u></u>							Approximate Interval Between Onset and Death <u>Days</u> <u>years</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>008188</u>		29d. DATE SIGNED (Month, Day, Year) <u>March 24, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Hugo G. Graziani, 717 Pershing Dr., Silver Spring, MD 20910</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 27 1995</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11270

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rosalee J. Poston				2. DATE OF DEATH MONTH DAY YEAR March 24 1995		3. TIME OF DEATH 1:20 PM	
4. SOCIAL SECURITY NUMBER 314-16-8337		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 4, 1923	
9a. FACILITY NAME (If not institution, give street and number) Springbrook Adventist Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Virginia		10b. COUNTY Fairfax		10c. CITY, TOWN OR LOCATION Reston		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11850 South Lakes Court				10f. ZIP CODE 22091		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) G. Oscar Morton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Elizabeth Joseph			
19a. INFORMANT'S NAME (Type/Print) John Bulach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6821 Jarett Road, Derwood, Maryland 20855			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory		DATE 3/28		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Andrew J. Furth</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. POST OBSTRUCTIVE PNEUMONIA					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. LUNG MASS / PROBABLE CARCINOMA					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. CHRONIC OBSTRUCTIVE LUNG DISEASE					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Summ</i>				29c. LICENSE NUMBER D31563		29d. DATE SIGNED (Month, Day, Year) MARCH 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES M. BENNER MD 11251 LOCKWOOD DRIVE, SILVERSPRING 20901							
31. DATE FILED (Month, Day, Year) MAR 30 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11271

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John C. Parker</i>				2. DATE OF DEATH MONTH <i>MARCH</i> DAY <i>28</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>2:35P</i> M	
4. SOCIAL SECURITY NUMBER <i>298-10-4962</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7. DATE OF BIRTH (Month, Day, Year) <i>Nov 15, 1912</i>				8. BIRTHPLACE (State or Foreign Country) <i>Unknown</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>				9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Bethesda</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5721 Grosvenor Lane</i>				10f. ZIP CODE <i>20814</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Unknown</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Unknown</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Unavailable</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Unavailable</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Lawrence L. Bell, Esquire</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11921 Rockville Pike, 3d Floor, Rockville, MD 20852</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glenwood Cemetery</i>				20c. LOCATION — City or Town, State <i>3-29 Washington, D.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. A. Bell</i>				22. NAME AND ADDRESS OF FACILITY <i>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute Pneumonia</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Unsepsis</i> <i>c. Dehydration</i> <i>d. Atrial Fibrillation</i>								Approximate Interval Between Onset and Death <i>3/95</i> <i>3/95</i> <i>3/95</i> <i>3/95</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CNF, DMID, ASIVO, Semic Automatic</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. B. Patrick III MD</i>				29c. LICENSE NUMBER <i>D17729</i>				29d. DATE SIGNED (Month/Day, Year) <i>3/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>G.B. Patrick III MD 9221 Colesville Rd SS, Md 20910</i>									
31. DATE FILED (Month, Day, Year) <i>MAR 31 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11272

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annie Pauline Pavey				2. DATE OF DEATH MONTH DAY YEAR March 28 1995		3. TIME OF DEATH 6:00 A.M.	
4. SOCIAL SECURITY NUMBER 578-05-7433		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1913	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Sylvan Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2700 Barker Street	
10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Joseph A. A. Beahm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Deavers			
19a. INFORMANT'S NAME (Type/Print) Gerald D. Pavey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Markham Street Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 4/3/95		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death Immediate More than 5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 01120		29d. DATE SIGNED (Month, Day, Year) March 29 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter E. Goozh, M.D. 2309 Shorefield Road Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #11, 3/23/95 MRT Montgomery County 11273  
 1 - FOR STATE REGISTRAR  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edgar Ebron Quinto				2. DATE OF DEATH MONTH DAY YEAR March 16, 1995				3. TIME OF DEATH 11:02 p. m.			
4. SOCIAL SECURITY NUMBER 554-04-1109				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly				9c. COUNTY OF DEATH Prince Georges			
10a. STATE Maryland				10b. COUNTY Prince Georges				10c. CITY, TOWN OR LOCATION Hyattsville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7741 Emerson Road				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Filipino				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HVAC Supervisor			
17. FATHER'S NAME (First, Middle, Last) Mena Reyes Quinto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecilia Ebron				19. INFORMANT'S NAME (Type/Print) Percy S. Baroma			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7741 Emerson Rd., Hyattsville, Maryland 20784				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 3/24			
20c. LOCATION — City or Town, State Silver Spring, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease b. Hypertension c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 3 mos. 5 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Asuncion M. Soriano, MD				29c. LICENSE NUMBER D17128				29d. DATE SIGNED (Month, Day, Year) 3/17/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Asuncion M. Soriano, MD 119 Capitol Hgts. Blvd. Capitol Hgts., Md. 20743				31. DATE FILED (Month, Day, Year) MAR 21 1995				32. REGISTRAR'S SIGNATURE John [illegible]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11274

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dan C. Roberts				2. DATE OF DEATH MONTH DAY YEAR March, 24, 1995				3. TIME OF DEATH 11:47A M							
4. SOCIAL SECURITY NUMBER 409-48-3921		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 8-15-22		8. BIRTHPLACE (State or Foreign Country) Mt. City, TN				
9a. FACILITY NAME (If not institution, give street and number) Perry Point VA Hospital					9b. CITY, TOWN OR LOCATION OF DEATH Perryville				9c. COUNTY OF DEATH Cecil						
RESIDENCE OF DECEDENT															
10a. STATE PA		10b. COUNTY Lancaster			10c. CITY, TOWN OR LOCATION Little Britain Township				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER 141 Jubilee Rd.					10f. ZIP CODE 17563			10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist				16b. KIND OF BUSINESS/INDUSTRY Manufacturing							
17. FATHER'S NAME (First, Middle, Last) W. L. Roberts						18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Pleasant									
19a. INFORMANT'S NAME (Type/Print) Hazel G. Roberts						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 141 Jubilee Rd. Peach Bottom, PA 17563									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Baptist Cem. 3-28-95 Rising Sun, MD				20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Edward L. Collins Funeral Home, Inc. 86 Pine St. Oxford PA									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease with Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. due to Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER  A.J. LUCCO, M.D., VA Medical Center, Perry Point, MD 21902								29c. LICENSE NUMBER D30951		29d. DATE SIGNED (Month, Day, Year) 3-24-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.J. LUCCO, M.D., VA Medical Center, Perry Point, MD 21902															
31. DATE FILED (Month, Day, Year) MAR 29 1995						32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




9  
+10A



95 11275

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Arthur Monroe Ryan</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>8:50A</b> M	
4. SOCIAL SECURITY NUMBER <b>213-01-8044</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>03</b> DAYS <b>01</b>		IF UNDER 24 HRS. HOURS <b>01</b> MIN. <b>20</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>03-01-1920</b>				8. BIRTHPLACE (State or Foreign Country) <b>MD</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Perry Point VA Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Perry Point</b>				9c. COUNTY OF DEATH <b>Cecil</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>659 Otsego Street</b>				10f. ZIP CODE <b>21078</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1942 - 1945</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Funding Control Clerk</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William L. Ryan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Terry</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Verna L. Ryan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>659 Otsego St., Havre de Grace, MD 21078</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Paul's Lutheran Cem. 4/1</b>		DATE <b>4/1</b>		20c. LOCATION — City or Town, State <b>Aberdeen, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Pneumonia</b> b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Hypertension</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>151094-1</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-29-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MELECTA SANTOS, M.D., VA Medical Center, Perry Point, MD 21902</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH			
Dominic John Retrossa				March 31, 1995				M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
212-22-6784		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		67 YRS.		May 28, 1927		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
1502 Bayview Drive				Havre de Grace				Harford			
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
Maryland				Harford		Havre de Grace				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
1502 Bayview Drive				21078				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12)				College (1-4 or 5+)				Management Analysis			
4								Federal Government			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Angelo Retrossa				Josephine Morrelli							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Mrs. Janice Marie Retrossa				1502 Bayview Dr., Havre de Grace, MD 21078							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		OATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Mt. Erin Cemetery		4/3		Havre de Grace, MD					
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Madelyn Mitchell Shant				Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. CA in lung & metastasis											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?			
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined											
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER			
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				John D. Yun, M.D.				D12190			
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
John D. Yun, M.D. Havre de Grace, MD				APR 04 1995				John D. Yun, M.D.			



95 11277

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elva May Royston				2. DATE OF DEATH MONTH 4 DAY 1 YEAR 95		3. TIME OF DEATH 07:22 a.m.	
4. SOCIAL SECURITY NUMBER 220-01-2226		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 23, 1915	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3711 Mt. Carmel Road		9b. CITY, TOWN OR LOCATION OF DEATH Upperco	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Upperco				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3711 Mt. Carmel Road	
10f. ZIP CODE 21155				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Daniel Zachariah Heiss				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude May Royston			
19a. INFORMANT'S NAME (Type/Print) C. Russell Royston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Mt. Carmel Rd, Upperco, MD 21155			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem Grd 4/4		20c. LOCATION — City or Town, State Timonium, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myelofibrosis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. H. Heister, MD</i>				29c. LICENSE NUMBER D33320		29d. DATE SIGNED (Month, Day, Year) 4/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) F.M. G. 10th, II, MD 95 Carroll St. Westminster, MD							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11278

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Helen I. Randall</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>29</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>5:05</u> <u>a</u> <u>m</u>	
4. SOCIAL SECURITY NUMBER <u>080 - 07 - 2974</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>74</u> YRS.	IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>	IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>	7. DATE OF BIRTH (Month, Day, Year) <u>Sept 28, 1920</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Missouri</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Lorien Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Columbia</u>	
9c. COUNTY OF DEATH <u>Howard</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Howard</u>	
10c. CITY, TOWN OR LOCATION <u>Columbia</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>10919 Rock Coast Road</u>	
10f. ZIP CODE <u>21044</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Grade 12</u> College (1-4 or 5+) <u>  </u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Dental Assistant</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Health Care Industry</u>	
17. FATHER'S NAME (First, Middle, Last) <u>George Hooley</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Genevieve Delille</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Ronald F. Smith</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>22 Boshier Drive, Albany, New York 12205</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		20c. LOCATION — City or Town, State <u>4/1 Valatie, New York</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Donaldson Funeral Home, P.A.</u> <u>313 Talbott Ave. Laurel, Maryland 20707</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Dementia</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>  </u> DUE TO (OR AS A CONSEQUENCE OF):							
d. <u>  </u> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D-60468</u>		29d. DATE SIGNED (Month, Day, Year) <u>3-29-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>PIERCE 11055 LITTLE PATENT PARKWAY Columbia, MD 21044</u>							
31. DATE FILED (Month, Day, Year) <u>APR 03 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


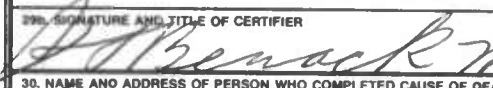
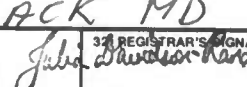
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11279

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVADNA IRIS RUEGER</b>				2. DATE OF DEATH DAY MONTH YEAR <b>MARCH 30 1995</b>		3. TIME OF DEATH <b>7:40 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>268-62-4632</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 19, 1900</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>RANDOLPH HILLS NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>WHEATON</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1415 GLENALLAN AVE.</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALFRED W. ERNST</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY E. SEILER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAUREN J. RUEGER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		DATE <b>3/31</b>		20c. LOCATION — City or Town, State <b>RIVERDALE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MD00091</b>				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>3 days</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>					
		29c. LICENSE NUMBER <b>D557</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. T. BENACK MD 4115 Colie DR., Wheaton, MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11280

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Roland</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>24</b> YEAR <b>95</b>				3. TIME OF DEATH <b>11:23 PM</b>	
4. SOCIAL SECURITY NUMBER <b>021-14-9600</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) <b>JULY 14, 1919</b>				8. BIRTHPLACE (State or Foreign Country) <b>FALL RIVER, MA</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>OXON HILL</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1313 SOUTHERN AVE</b>				10f. ZIP CODE <b>20745</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BUFFER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>JEWELRY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LEO ROCHON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIAN ARSENAULT</b>					
19a. INFORMANT'S NAME (Type/Print) <b>RITA CELINA ROCHON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5702 SARGENT RD. CHILLUM MD 20782</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NOTRE DAME CEMETERY</b>				DATE <b>3/29/95</b> 20c. LOCATION — City or Town, State <b>FALL RIVER, MA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>fractured hip</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>March 15, 1995</b>		28b. TIME OF INJURY <b>unknown</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Fell</b>	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Nursing Home</b>				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Maryland 6500 Riggs Road Hyattsville</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D08546</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 25 95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John J. Tumber 8218 Wisconsin Ave</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11281

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORMAN RICHARDSON</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>23</b> YEAR <b>95</b>		3. TIME OF DEATH <b>7:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-44-7761</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 21, 1934</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Wheaton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3009 Birchtree Lane</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Fire Chief</b>		16b. KIND OF BUSINESS/INDUSTRY <b>D.C. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ambrose Richardson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Winifred Butler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cherry S. Richardson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3009 Birchtree Lane, Wheaton, MD 20906</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Washington Crematory</b> <b>March 24</b>		20c. LOCATION — City or Town, State <b>Laurel, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>McGuire funeral Service, Inc. 20012</b> <b>7400 Georgia Ave. N.W., Washington, D.C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Bilateral Thalamic hemorrhages</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> <b>Approximate Interval Between Onset and Death</b> <b>3 wks</b> <b>2 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcohol Abuse History</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Internist</b>				29c. LICENSE NUMBER <b>D35045</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-23-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Phil Henjum, MD 13575 Conn. Ave #300 Silver Spring, MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11282

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Orling Simons				2. DATE OF DEATH MONTH DAY YEAR April 03 1995				3. TIME OF DEATH 4:30 P M	
4. SOCIAL SECURITY NUMBER 224-22-3266		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) April 4, 1923				8. BIRTHPLACE (State or Foreign Country) West Virginia					
9a. FACILITY NAME (If not institution, give street and number) 101 Cherry Street				9b. CITY, TOWN OR LOCATION OF DEATH North East				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 101 Cherry Street				10f. ZIP CODE 21901		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES US Army WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Off Bearer				16b. KIND OF BUSINESS/INDUSTRY Sawmill/Lumber Manuf.	
17. FATHER'S NAME (First, Middle, Last) John Bryant Simons				18. MOTHER'S NAME (First, Middle, Maiden Surname) Princess Cornett					
19a. INFORMANT'S NAME (Type/Print) Susan L. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Rowland Road, Coloma, Maryland 21917					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) North East Methodist Cem. 4/6		DATE		20c. LOCATION — City or Town, State North East, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East MD 21901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>pulmonary edema</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>cardiomyopathy (congestive)</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>diabetes mellitus</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 37093		29d. DATE SIGNED (Month, Day, Year) 4/3/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIANNE CLOEREN, PERRY POINT VAMC, PERRY POINT, MD									
31. DATE FILED (Month, Day, Year) APR 04 1995		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11283

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Frank Szrom</b>		2. DATE OF DEATH MONTH DAY YEAR <b>March 29, 1995</b>		3. TIME OF DEATH <b>7:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-30-4362</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>805 S. Fountain Green Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bel Air</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Bel Air</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>805 S. Fountain Green Road</b>		10f. ZIP CODE <b>21015</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Iron Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Theodore Szrom</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary (u/k) Wilk</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary E. Szrom</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>805 S. Fountain Green Road, Bel Air, Maryland 21015</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baker's Cemetery 4/1/95</b>		20c. LOCATION — City or Town, State <b>Aberdeen, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen A. Mergle</i>		22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Heart failure Cor pulmonale</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Pulmonary Sarcoidosis</b> DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____					Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i> MD.		29c. LICENSE NUMBER <b>D14544</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 29, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>IAN DOUGLAS SOMERVILLE 400 LEWIS ST. HANNE DEGRAKE MD</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		32. REGISTRAR'S SIGNATURE <i>John [Signature]</i> <b>21078</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11284

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RANDOLPH B. SHINDLE, JR.				2. DATE OF DEATH MONTH 2 DAY 27 YEAR 95		3. TIME OF DEATH 5:17 A M	
4. SOCIAL SECURITY NUMBER 218-84-2180		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9 28 62	
8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD.				9a. FACILITY NAME (If not institution, give street and number) 31852 MT. HERMAN ROAD		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE MD.		10b. COUNTY WICOMICO	
10c. CITY, TOWN OR LOCATION SALISBURY				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 31852 MT. HERMAN ROAD,	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th + 1 year College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UPS		16b. KIND OF BUSINESS/INDUSTRY MAIL	
17. FATHER'S NAME (First, Middle, Last) RANDOLPH B. SHINDLE, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDITH MISKIMON			
19a. INFORMANT'S NAME (Type/Print) EDITH REAVES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Entombment 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SPRINGHILL MEM. G.3-2		20c. LOCATION — City or Town, State HEBRON, MD. 21830	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Doretta B. Jolley				22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL, 1213 JERSEY ROAD, SALISBURY, MD. 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypoxia b. Pulmonary Kaposi's Sarcoma c. AIDS d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate Interval Between Onset and Death MIN. to hours 6 Months 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV Wasting Syndrome Pancytopenia MAI Complex Hx pneumocystis carinii pneumonia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? N/A							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jay Ivan SERV MD				29c. LICENSE NUMBER D34206		29d. DATE SIGNED (Month, Day, Year) 2-28-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jay Ivan SERV MD - 5072 Porsey Hall Dr., #103, Elmont City, NY 11042							
31. DATE FILED (Month, Day, Year) MAR 22 1995				32. REGISTRAR'S SIGNATURE John A. Hatcher			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11285

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Virginia SHILLINGBURG				2. DATE OF DEATH MONTH DAY YEAR March 17 95		3. TIME OF DEATH 12 05a. m	
4. SOCIAL SECURITY NUMBER 220-38-0087		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 18, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 421 Hammond St., Apt. 201		9b. CITY, TOWN OR LOCATION OF DEATH Westernport		9c. COUNTY OF DEATH Allegany	
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Westernport		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 421 Hammond St., Apt. 201				10f. ZIP CODE 21562		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) William Webster Cooper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Zalemma Ethel Rotruck			
19a. INFORMANT'S NAME (Type/Print) Marguerite Fink				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Cromer Street, Westernport, Maryland 21562			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) White Church Cemetery 3/19		20c. LOCATION — City or Town, State Oakland, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brodley H. Howard				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION DISEASE 5min Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ARTERIO SCLEROTIC CARDIOVASCULAR 15YRS b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease depression							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Donald Manger M.D.				29c. LICENSE NUMBER D09231		29d. DATE SIGNED (Month, Day, Year) 3-28-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Donald Manger, MD 11600 Bedford Road, Cumberland, Maryland 21502							
31. DATE FILED (Month, Day, Year) APR 3 1995				32. REGISTRAR'S SIGNATURE Rueben Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11286

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Sowers</b> LENA ROOSEVELT SOWERS				2. DATE OF DEATH MONTH <b>3</b> DAY <b>29</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>223-44-1254</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-3-1907</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Chapel Hill Nursing Home</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		8c. COUNTY OF DEATH <b>VA.</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>MD.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4511 Robosson Road</b>				10f. ZIP CODE <b>21133</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>7</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>companion to elderly</b>		16b. KIND OF BUSINESS/INDUSTRY <b>companion</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Miller</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hilda Bright</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marvin Sowers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 E. Baltimore St., Taneytown, Md. 21787</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Crematory 3/30/95</b>		20c. LOCATION — City or Town, State <b>Hampstead, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Hilda L Lemmer</b>				22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home 91 Willis St., Westminster, Md. 21157</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Dementia Alzheimer's Type</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>10 yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William R O'Rourke MD</b>				29c. LICENSE NUMBER <b>DO9389</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William R. O'Rourke, M.D. 150 W. Main Street, Westminster, MD 21157</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE <b>Juba A. H. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11287

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elsie Louise Swetnam</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MARCH 28 1995</i>		3. TIME OF DEATH <i>1820</i> M	
4. SOCIAL SECURITY NUMBER <i>820-05-8721</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 9, 1913</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Deaton Specialty Hospital &amp; Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE <i>Maryland</i>		10b. COUNTY		10e. STREET AND NUMBER <i>600 Light Street #803</i>		10f. ZIP CODE <i>21230</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Grade 12</i> College (1-4 or 5+) <i>Homemaker</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Edward B. Wayson</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Creegan</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Joe Swetnam</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12508 Rockledge Drive Bowie, Md. 20715</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cedar Hill Cemetery</i>		DATE <i>3/31</i>		20c. LOCATION — City or Town, State <i>Suitland, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gregory S. K...</i>				22. NAME AND ADDRESS OF FACILITY <i>Donaldson Funeral Home P.A. 313 Talbott Avenue Laurel, Md. 20707</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>NEOPLASM, CERVIX WITH METASTASES</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>CHRONIC OBSTRUCTIVE PULMONARY DIS., RHEUMATOID ARTHRITIS</i> c. <i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></i> d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC OBSTRUCTIVE PULMONARY DIS., RHEUMATOID ARTHRITIS</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ben C. Williams</i>				29c. LICENSE NUMBER <i>D31136</i>		29d. DATE SIGNED (Month, Day, Year) <i>MARCH 29, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BORIAN C. WALLACE, MD 611 S. CHARLES ST., BALTIMORE, MD 21230</i>							
31. DATE FILED (Month, Day, Year) <i>APR 03 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AGNES M SPECHT</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>27</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>11:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213 - 74 - 5858</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) <b>Oct 27, 1904</b>				8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Laurel Regional Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Laurel</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <b>600 4th Street</b>				10f. ZIP CODE <b>20707</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade 11</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Howard T. Burrows</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maud Duvall</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Evelyn Specht</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Compton Avenue, Laurel, Maryland 20707</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 3/30</b>				20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Cardio-respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>minutes</b> <b>minutes</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hyperthyroidism, hypertension, breast carcinoma (remote) occasional congestive heart failure</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Abeyon MD</b>				29c. LICENSE NUMBER <b>D25925</b>				29d. DATE SIGNED (Month, Day, Year) <b>Mar 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Berger #205, 7720 Wisconsin Ave Bethesda Md 20814</b>									
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #18, 3/27/95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

25011289

1. DECEDENT'S NAME (First, Middle, Last) LEO EDWARD SCANLON				2. DATE OF DEATH MONTH DAY YEAR MARCH 21 95		3. TIME OF DEATH 7:45 P.M.					
4. SOCIAL SECURITY NUMBER 028-38-3184		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 30, 1946		8. BIRTHPLACE (State or Foreign Country) Massachusetts			
9a. FACILITY NAME (If not Institution, give street and number) 18559 SPLIT ROCK LANE RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH GERMANTOWN			9c. COUNTY OF DEATH MONTGOMERY				
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 18559 Splitrock Lane				10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1968 - 1970		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Program Analyst			16b. KIND OF BUSINESS/INDUSTRY U.S. Government						
17. FATHER'S NAME (First, Middle, Last) Leo Scanlon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Davis-Marie Morgan							
19a. INFORMANT'S NAME (Type/Print) Jaisiri Jaiwatana				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Montrose Blvd. 14A Houston, TX 77006							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory March 25, 1995 Alexandria, VA		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 3/21/95		28b. TIME OF INJURY found 7:30 p.m.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 18559 SPLIT ROCK LANE GERMANTOWN, MD.					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MARCH 22, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 PENN STREET BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) MAR 27 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

15

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


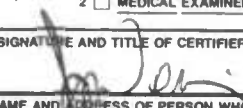
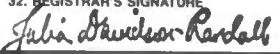




95 11290

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lillian R. Scheer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 27 1995</b>		3. TIME OF DEATH <b>5:58 A.</b>	
4. SOCIAL SECURITY NUMBER <b>578-34-3093</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 19 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Canada</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>8201 16th Street</b>	
10f. ZIP CODE <b>20910</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Business Woman</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Liquor</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Rachootin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Aronoff</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Stuart Scheer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10401 Grosvenor Place, Rockville MD 20852</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>King David Mem. Garden 3/28 Falls Church VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Respiratory Failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Chronic Obstructive Pulmonary Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Coronary Artery Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>Bronchiectasis</b>							
Approximate Interval Between Onset and Death 6 days 20 yrs 20 yrs 6 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>March 27 1995</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>024571</b>			
29d. DATE SIGNED (Month, Day, Year) <b>3/28/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jay Weiner MD 11501 Georgia Ave Wheaton MD 20902</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11291

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Malcolm Austin Simms, Jr.</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>27</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>6:45 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-284661</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>62</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>8/11/32</i>	8. BIRTHPLACE (State or Foreign Country) <i>Baltimore, MD</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>2254 Lake Drive</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Pasadena, MD</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Dickerson</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>21515 Dickerson Road</i>				10f. ZIP CODE <i>20842</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>June 1955 - Nov 1958</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Sales</i>		16b. KIND OF BUSINESS/INDUSTRY <i>MS Electronics</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Malcolm Austin Simms</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Angela Mueller Simms</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Katharine Hallambauer</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>POB 133 Dickerson, MD 20842</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Ignatius Cemetery</i>		20c. LOCATION — City or Town, State <i>Port Tobacco, Maryland</i>		20d. DATE <i>March 30, 1995</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara Jo McMullen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Chronic Lymphocytic Leukemia.</i> Approximate interval between Onset and Death <i>since 1989</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Agranulocytosis</i> (3 1994 months)					
		c. <i>Anemia</i> (3 1994 months)					
		d. <i>Thrombocytopenia.</i> (3 1994 months)					
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i>		29c. LICENSE NUMBER <i>D44973</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 27th 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Gurmeet S. Sawhney MD, 325 HOSPITAL DRIVE 202, GLENBURNIE, MD 21061</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 29 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Anderson-Russell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended # 17, #18 3/29/95 MRT Montgomery #292

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>Sally Louise Sandman</u>				2. DATE OF DEATH MONTH DAY YEAR <u>March 24, 1995</u>		3. TIME OF DEATH <u>12:30 P M</u>					
4. SOCIAL SECURITY NUMBER <u>081-14-6326</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 29, 1923</u>		8. BIRTHPLACE (State or Foreign Country) <u>New York</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>15120 Red Clover Drive</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>			9c. COUNTY OF DEATH <u>Montgomery</u>				
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Rockville</u>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <u>15120 Red Clover Drive</u>				10f. ZIP CODE <u>20853</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				
15. DECEASED'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		15b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>							
16. FATHER'S NAME (First, Middle, Last) <u>not available Dymetro Tymko</u>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <u>not available Magda Sheremeta</u>							
17a. INFORMANT'S NAME (Type/Print) <u>Arthur F. Sandman</u>				17b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>15120 Red Clover Drive, Rockville, Maryland 20853</u>							
18a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		18b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gate Of Heaven Cemetery</u>		18c. DATE <u>March 28, 1995</u>		18d. LOCATION — City or Town, State <u>Silver Spring, Maryland</u>					
19. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Delmar J. Santos</u> M00202				20. NAME AND ADDRESS OF FACILITY <u>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</u>							
21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>COLON Cancer</u>  Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.								Approximate Interval Between Onset and Death <u>1 yr</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								22. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		23. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
24. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		27. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY <u>M</u>		27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27d. DESCRIBE HOW INJURY OCCURRED			
		27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				27f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
28. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
28a. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				28b. LICENSE NUMBER <u>033688</u>		28c. DATE SIGNED (Month, Day, Year) <u>March 27, 1995</u>					
29. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <u>Kenneth Miller MD 18111 Prince Philip Dr. Olney, MD</u>											
30. DATE FILED (Month, Day, Year) <u>MAR 29 1995</u>				31. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



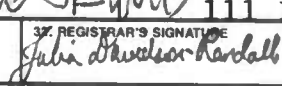
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DARCY Diantha SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 22, 1995</b>		3. TIME OF DEATH <b>06:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-08-6925</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>16</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 31, 1978</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Wisconsin</b>				9a. FACILITY NAME (If not institution, give street and number) <b>11117 TARA RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>POTOMAC</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Potomac</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>11117 Tara Road</b>	
10f. ZIP CODE <b>20854</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Not applicable</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Delbert D. Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Margaret Jackson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Delbert D. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11117 Tara Road, Potomac, Maryland 20854</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc. March 24, 1995</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00348</b>				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RIGHT VENTRICULAR DYSPLASIA</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 23, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARCO F. GOLWE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11294

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AILEEN FRANCES SHEEHAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 21 95</b>		3. TIME OF DEATH <b>11:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>033-18-0700</b>		5. SEX <b>1 M 2 XXF</b>		6. AGE (In yrs. last birthday) <b>68 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>June 13, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Prince George's General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>		10e. STREET AND NUMBER <b>4857 Cordell Avenue #709</b>	
10f. ZIP CODE <b>20814</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 X Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Kelleher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Gibson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eileen F. Sheehan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7218 Windsor Lane. Hyattsville, Maryland 20782</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 3/25/95 OATE</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Higgins</i> M00846				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. COPD.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. TRACHEO-ESOPHAGEAL FISTULA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. PNEUMONIA; SEPSIS RECURRENT.</b> Approximate Interval Between Onset and Death <b>&gt; 4-MONTHS</b> <b>&gt; ONE YEAR</b> <b>&gt; 4-MONTHS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Decubite ulcer; Anemia; Recurrent vomiting; osteoporosis; Anemia; CAD</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b> <b>N/A</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>							
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>G.S.S. Hospital</b> 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined							
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY		28c. INJURY AT WORK? <b>1 YES 2 X NO</b>	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. J. Rao</i>				29c. LICENSE NUMBER <b>D-34525</b>		29d. DATE/SIGNED (Month, Day, Year) <b>3/22/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. J. Rao, MD #22034000 MITCHELLVILLE ROAD; BOWIE-MD-20716</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES EMIL SITES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 24, 1995</b>		3. TIME OF DEATH <b>10:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>054-32-5773</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>January 27, 1938</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2000 SHOREFIELD ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRINGS</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>9224 Mintwood Street</b>				10f. ZIP CODE <b>20901</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>1962-1964</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Business Executive</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Emanuel L. Sites</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rama Dooley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Brian Michael Sites</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1134 St. Augustine Place Atlanta, Georgia 30306</b>			
20a. METHOD OF DISPOSITION <b>1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc. March 27, 1995</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b> M00335				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intra-Oral Gunshot Wound</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b> <b>partial</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		26a. DATE OF INJURY <b>3-24-95</b>		26b. TIME OF INJURY <b>8:15 AM</b>		26c. INJURY AT WORK? <b>1 YES 2 NO</b>	
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Parking lot Street</b>		26d. DESCRIBE NOW INJURY OCCURRED <b>self-inflicted gunshot</b>					
26e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Wheaton Regional Park Maryland</b>							
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dennis J. Chute M.D.</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 25, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DENNIS J. CHUTE M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11296

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marshall Franklin Smith				2. DATE OF DEATH MONTH DAY YEAR March 29 1995		3. TIME OF DEATH 9:50 P M	
4. SOCIAL SECURITY NUMBER 578-20-9744		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 4, 1899	
8. BIRTHPLACE (State or Foreign Country) Washington D.C.				9a. FACILITY NAME (If not institution, give street and number) Springbrook Adventist Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12617 McAdoo Court	
10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service	
17. FATHER'S NAME (First, Middle, Last) Frank Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence B. Norris			
19a. INFORMANT'S NAME (Type/Print) Dolores T. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12617 McAdoo Court Silver Spring, MD 20904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/1/95		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Andrew J. Cole</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 3 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. Chablani</i>				29c. LICENSE NUMBER D 42518		29d. DATE SIGNED (Month, Day, Year) March 30, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gul Chablani, M.D. 11119 Rockville Pike Suite 316 Rockville, MD 20852							
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

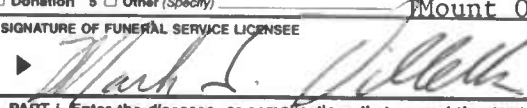
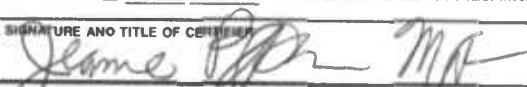
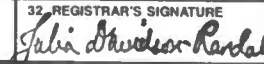
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11297

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Ann Stevens				2. DATE OF DEATH MONTH DAY YEAR March 22, 1995				3. TIME OF DEATH 12:30 P.M.	
4. SOCIAL SECURITY NUMBER 383-24-7165		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) 805 North Belgrade Road				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 805 North Belgrade Road				10f. ZIP CODE 20902	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home				17. FATHER'S NAME (First, Middle, Last) Patrick Dignan	
18. MOTHER'S NAME (First, Middle, Maiden Surname)				19a. INFORMANT'S NAME (Type/Print) Eleanor H. Stevens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 North Belgrade Road Silver Spring, Maryland 20902	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 3/27/95				20c. LOCATION — City or Town, State Detroit, Michigan	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis due to Non A Non B Hepatitis DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER  MA				29c. LICENSE NUMBER D 34032				29d. DATE SIGNED (Month, Day, Year) March 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeanne P. Asher, M.D. 3720 Farragut Avenue Kensington, Maryland 20895				31. DATE FILED (Month, Day, Year) MAR 28 1995				32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. DECEDENT'S NAME (First, Middle, Last) <b>ELVA L ELVA Louise Swaim</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:25 P</b> M	
4. SOCIAL SECURITY NUMBER <b>578-12-6763</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>Howard</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>	
10c. CITY, TOWN OR LOCATION <b>Columbia</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>9571 Transfer Road</b>	
10f. ZIP CODE <b>21045</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Williard E. Jones</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel B. Turner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard D. Swaim</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12100 Dalewood Drive Wheaton, Maryland 20902</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington National 3/28/95</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Arrio Ventricular Dissociation</b> Approximate interval Between Onset and Death <b>1hr</b>							
b. <b>ATRIAL Thrombus</b> <b>6 months</b>							
c. <b>Ischemic Cardiomyopathy</b> <b>1yr</b>							
d. <b>Atherosclerotic Cardiovascular Disease</b> <b>1yr</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertensive MIA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Maureen Coffee MD</b>				29c. LICENSE NUMBER <b>D 38190</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/25/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Maureen Coffee MD 9650 Santiago Road Columbia MD 21045</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11299

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marian M. Spitzer</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-80-6682</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1904</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		8c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>West Hyattsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6519 19th Place</b>				10f. ZIP CODE <b>20782</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Horrace C. Hay</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Inez Altfather</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Thraillkill</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14122 Chadwicks Lane Rockville, MD 20853</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery March 29, 1995</b>		20c. LOCATION — City or Town, State <b>Brentwood, MD</b>		20d. DATE <b>March 29, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pulmonary Edema</b>							Approximate Interval Between Onset and Death <b>5 hours</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):							<b>YEARS</b>
c. <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF):							<b>YEARS</b>
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Vascular Accident</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>NAME Stanley Frishton MD</b>				29c. LICENSE NUMBER <b>030900</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wayne S. Frishton 9901 Medical Center Dr Rockville MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11300

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NETTIE TAYLOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03/29/95</b>		3. TIME OF DEATH <b>8:40 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>266-10-9123</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 2, 1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FORT WASHINGTON MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FORT WASHINGTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>TEMPLE HILLS</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>#3808 GULL ROAD</b>				10f. ZIP CODE <b>20748</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4TH GRADE</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SEAMSTRESS/DRY CLEANER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CLOTHING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM HOPKINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH TRIPPLETT HOPKINS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>IDA AVENT / EDWINA BECKETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#3808 GULL ROAD, TEMPLE HILLS, MARYLAND 20748</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY MEMORIAL PARK 4/5/95</b>		20c. LOCATION — City or Town, State <b>HYATTSVILLE, MARYLAND</b>		20d. DATE <b>4/5/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lydia C. Thornton Johnson</i> <b>LYDIA C. THORNTON JOHNSON M00583</b>				22. NAME AND ADDRESS OF FACILITY <b>THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Nephrosclerosis</b>							Approximate Interval Between Onset and Death <b>1 week</b> <b>2 month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Nephrosclerosis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Oswald L. Haye</i>		29c. LICENSE NUMBER <b>D26352</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>OSWALD L. HAYE 9131 PISCATAWAY ROAD, CLINTON MD. 20735</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


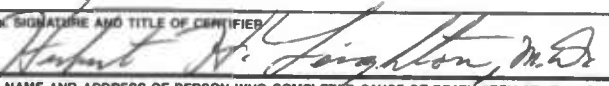
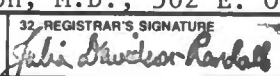
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11301

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES BRETT TALLMAN, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 26 1995</b>		3. TIME OF DEATH <b>3:15 p m</b>	
4. SOCIAL SECURITY NUMBER <b>233-41-7403</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>1</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 25, 1993</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>		9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>W. VA.</b>		10b. COUNTY <b>GRANT</b>		10c. CITY, TOWN OR LOCATION <b>MT. STORM</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. 93</b>				10f. ZIP CODE <b>26739</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>0</b> Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>INFANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>NEVER WORKED</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES BRETT TALLMAN, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VICTORIA LYNN BENNETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES B. TALLMAN, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 25 GORMANIA, W. VA. 26720</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. STORM CEMETERY</b>		DATE <b>3/30</b>		20c. LOCATION — City or Town, State <b>MT. STORM, W.VA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Ventricular Arrhythmia, Acute</b> DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death <b>1 hour</b>
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Congenital Heart Disease including Tetralogy of Fallot</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>22 Mos.</b>
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Heart surgery performed 12/14/94, Ruby Memorial Hosp.</b> <b>Post-Op complicated by sepsis-lossof both feet, tips of fingers.</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 05658</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 28, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11302

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen F. Thornett				2. DATE OF DEATH MONTH DAY YEAR March 26, 1995				3. TIME OF DEATH 11:20 P M							
4. SOCIAL SECURITY NUMBER 577-72-1804		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 9, 1902		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) Rockville Nursing Home						9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Potomac				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 10900 Pleasant Hill Drive						10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) George Fleishell						18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Neff									
19a. INFORMANT'S NAME (Type/Print) Ann T.M. Haack						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10900 Pleasant Hill Drive, Potomac, MD 20854									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE St. Gabriel's Cemetery March 31, 1995				20c. LOCATION — City or Town, State Potomac, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805											
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 week b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): years c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): years d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frauke Westphal M.D.</i>						29c. LICENSE NUMBER D19785				29d. DATE SIGNED (Month, Day, Year) March 27, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frauke Westphal, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851															
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11303

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES LINWOOD TAFT II</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:00</b> P M	
4. SOCIAL SECURITY NUMBER <b>610-74-0669</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>1</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 27, 1993</b>	
8. BIRTHPLACE (State or Foreign Country) <b>California</b>				9. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>				11. COUNTY OF DEATH <b>MONTGOMERY</b>			
12a. STATE <b>Maryland</b>		12b. COUNTY <b>Montgomery</b>		12c. CITY, TOWN OR LOCATION <b>Rockville</b>		12d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. STREET AND NUMBER <b>563 Reading Terrace</b>				14. ZIP CODE <b>20850</b>		15. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
16. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>None</b>		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		22. KIND OF BUSINESS/INDUSTRY <b>None</b>			
23. FATHER'S NAME (First, Middle, Last) <b>James Linwood Taft, Jr.</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Tiffany Hope Alexander</b>			
25. INFORMANT'S NAME (Type/Print) <b>Tiffany H. Taft</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garden Memorial Park</b>		29. DATE <b>4-1</b>		30. LOCATION — City or Town, State <b>Jackson, Mississippi</b>	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Eileen H. Rapp</b>				32. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>12 hours</b> b. <b>DISTRIBUTIVE SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF): <b>30 min</b> c. <b>CARDIO PULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>15 min</b> d. <b>VERTICAL TRANSMISSION AIDS</b> <b>16 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY <b>M</b>		38. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)				40. DESCRIBE HOW INJURY OCCURED			
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
42. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
43. SIGNATURE AND TITLE OF CERTIFIER <b>Robert M. Oliveri MD</b>				44. LICENSE NUMBER <b>D-39364</b>		45. DATE SIGNED (Month, Day, Year) <b>3/24/95</b>	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>							
47. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>		48. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11304

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Rebecca A Terry</u>				2. DATE OF DEATH MONTH <u>MAR</u> DAY <u>25</u> YEAR <u>95</u>		3. TIME OF DEATH <u>10 50 P. M.</u>	
4. SOCIAL SECURITY NUMBER <u>578-32-2665</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>85</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 31, 1909</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Suburban Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Bethesda</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>N/A</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Washington, D.C.</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <u>2131 O Street, N.W.</u>				10f. ZIP CODE <u>20037</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Unknown</u> College (1-4 or 5+) <u>Unknown</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Unknown</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Unknown</u>			
17. FATHER'S NAME (First, Middle, Last) <u>William Thomas Bellows</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Alberta Mathews</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Joseph F. Edwards</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1521 S. Street N.W., Washington, D.C. 20009</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Baltimore Washington Crematory</u> DATE <u>3/28</u>		20c. LOCATION — City or Town, State <u>Laurel, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James E. McGuire</u>				22. NAME AND ADDRESS OF FACILITY <u>McGuire Funeral Service, Inc. 20012</u> <u>7400 Georgia Ave. N.W., Washington, D.C.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <u>Respiratory failure</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart Failure</u> <u>Aluminum Poisoning</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Joel Schafman M.D.</u>				29c. LICENSE NUMBER <u>020516</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/27/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>9410 Old Georgetown Rd Bethesda MD 20814 Joel Schafman</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 29 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Radloff</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #6 3/24/95 MRT Montgomery County 95 11305

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wesner Thrasybule, Sr.				2. DATE OF DEATH MONTH DAY YEAR March 21 1995		3. TIME OF DEATH 8:30 P M			
4. SOCIAL SECURITY NUMBER 435-33-3025		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79-80 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 4, 1915		8. BIRTHPLACE (State or Foreign Country) Haiti	
9a. FACILITY NAME (If not institution, give street and number) 620 University Blvd., W.				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring			9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 620 University Blvd. W.				10f. ZIP CODE 20901		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professor		16b. KIND OF BUSINESS/INDUSTRY Education					
17. FATHER'S NAME (First, Middle, Last) Emmanuel Thrasybule				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Probst					
19a. INFORMANT'S NAME (Type/Print) Maryse Thrasybule				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 University Blvd., W. Silver Spring, MD 20901					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		DATE 3/25		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Heart Failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary artery disease of the Prostate</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>10 yrs</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER D05937		29d. DATE SIGNED (Month, Day, Year) 03-22-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT KRADER MD 10313 GEORGETOWN RD SILVER SPRING									
31. DATE FILED (Month, Day, Year) MAR 24 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11306

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FUN CHEN TANG</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>24</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>1022 A M</b>	
4. SOCIAL SECURITY NUMBER <b>228-04-1594</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 2, 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>North Potomac</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13859 Grey Colt Drive</b>				10f. ZIP CODE <b>20878</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Asian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Not Stated</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Not Stated</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Wing Hong Tang</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13859 Grey Colt Drive, North Potomac, MD 20878</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chambers Crematory</b>		DATE <b>3/28</b>		20c. LOCATION — City or Town, State <b>Riverdale, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bernie A. Funerary III</b>				22. NAME AND ADDRESS OF FACILITY <b>W.W. Chambers</b> <b>9241 Columbia Blvd., Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Cardiac Arrest</b> b. <b>Atherosclerotic cardiovascular disease</b> c. <b>diabetes</b> d.  Approximate interval Between Onset and Death <b>minutes</b> <b>5 years</b> <b>20 yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic renal failure</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Raymond Bass</b>				29c. LICENSE NUMBER <b>D 21340</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 24, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAYMOND BASS 3941 FERRARA WHEATON, MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Radall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 - 1000 = 0

1000

1000 - 1000 = 0

1000

1000

1000 - 1000 = 0

1000 - 1000 = 0

1000 - 1000 = 0

1000

1000

1000 - 1000 = 0

1000

1000

1000

1000

1000 - 1000 = 0

1000 - 1000 = 0

1000 - 1000 = 0

1000 - 1000 = 0

1000 - 1000 = 0

1000 - 1000 = 0

1000

95 11307

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rev. Marian K. Tate				2. DATE OF DEATH MONTH DAY YEAR March 28 1995				3. TIME OF DEATH 12 Noon M							
4. SOCIAL SECURITY NUMBER 579-44-8369		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 2, 1903	8. BIRTHPLACE (State or Foreign Country) Washington D.C.										
9a. FACILITY NAME (If not institution, give street and number) Manor Care Silver Spring				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring			9c. COUNTY OF DEATH Montgomery								
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								
10e. STREET AND NUMBER 8505 Springvale Road Apt. 302				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 5+			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Minister			16b. KIND OF BUSINESS/INDUSTRY Religion									
17. FATHER'S NAME (First, Middle, Last) Frank Keefer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Nauman											
19a. INFORMANT'S NAME (Type/Print) Kaye M. White				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Blueford Road Kensington, Maryland 20895											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery 3/31/95			20c. LOCATION — City or Town, State Washington D.C.										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil.Spr. MD 20901											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Anteroseptal Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 31 Days 35 Days Years								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Anemia; Mild Dementia								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER D 25344		29d. DATE SIGNED (Month, Day, Year) March 29, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert J. Ginsberg, M.D. 2415 Musgrove Road #209 Silver Spring Maryland 20904										31. DATE FILED (Month, Day, Year) MAR 30 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11308

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Marilyn Ann Vermilye				2. DATE OF DEATH MONTH DAY YEAR March 28, 1995		3. TIME OF DEATH 8:30 A M	
4. SOCIAL SECURITY NUMBER 506-26-5289		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 29, 1928	
8. BIRTHPLACE (State or Foreign Country) Nebraska				9a. FACILITY NAME (If not institution, give street and number) 4952 Sentinel Drive, #101		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4952 Sentinel Drive, #101	
10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Credit Manager		16b. KIND OF BUSINESS/INDUSTRY Building Services	
17. FATHER'S NAME (First, Middle, Last) Lyle A. Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ann G. O'Hara			
19a. INFORMANT'S NAME (Type/Print) Susan M. Barnhart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Cobblestone Lane, Woodstock, Georgia 30188			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) March 29, 1995 Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thichule P. Kutto M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Smoking DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 months 50 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Eugene A. Voith M.D.				29c. LICENSE NUMBER D14253		29d. DATE SIGNED (Month, Day, Year) March 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marjorie A. Voith, M.D., 5530 Wisconsin Avenue #830, Chevy Chase, MD 20815-4401							
31. DATE FILED (Month, Day, Year) MAR 29 1995				32. REGISTRAR'S SIGNATURE John A. Swanson-Russell			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11309

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Helen Virts				2. DATE OF DEATH MONTH DAY YEAR March 26 1995		3. TIME OF DEATH 11:55 p.m.	
4. SOCIAL SECURITY NUMBER 275-36-8556		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov 30 1931		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) Egle Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Lonoconing		9c. COUNTY OF DEATH Allegany	
10a. STATE Md		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Lonoconing		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 57 Jackson St.				10f. ZIP CODE 21539		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) William Thomas Beeman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Champanella			
19a. INFORMANT'S NAME (Type/Print) William Virts				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 1778 Md Hwy Swanton, Md 21561			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Turner Cemetery Mar 29 '95		20c. LOCATION — City or Town, State Swanton, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock Funeral Home PO Box 523 Kitzmiller, Md. 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiomegaly + Congestive Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Renal failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Diffuse Vascular Insufficiency</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Diabetes mellitus</u> Approximate Interval Between Onset and Death 3 wks 1 year 4 years 15 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L.R. Miles 10 St. Peter's Pl. Lonoconing, Md 21539							
31. DATE FILED (Month, Day, Year) MAR 29 1995		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CC-1

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961 8 3 9AM



95 11310

Amended #6, 3/31/95, J.W. Montgomery Co.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JUDITH ANN VITALE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 29, 1995</b>		3. TIME OF DEATH P M <b>5:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>188-32-7708</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54-55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 13, 1940</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>18001 Fertile Meadow Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>18001 Fertile Meadow Court</b>	
10f. ZIP CODE <b>20877</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>—</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Education Specialist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Stanley Burkhardt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Judith Ann Allgood</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edmund Vitale, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18001 Fertile Meadow Court, Gaithersburg, MD 20877</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>March 31, 1995</b> <b>Montgomery Crematorium, Inc.</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Latta</i> M00348				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Small Cell Carcinoma of the Lung, metastatic to the Liver, Bones &amp; Brain</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>14 Months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Albert E. Rolle, M.D.</i>				29c. LICENSE NUMBER <b>D O 7967</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 29, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Albert E. Rolle, M.D., 3800 Reservoir Rd., N.W., Washington, D.C. 20007</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Hardath</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11311

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA M Villiotti</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>27</b> YEAR <b>95</b>		3. TIME OF DEATH <b>3:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>167-50-4030</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 10, 1904</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Randolph Hills Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>11526 Soward Drive</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>Homemaker</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles S. LaScola</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Carol Villiotti</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11526 Soward Drive Silver Spring, Maryland 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 3/31/95 Silver Spring, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James E. Oodys</b>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Pneumonia</b> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fractured left hip</b>							Approximate interval between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>Feb 6-95</b>		28b. TIME OF INJURY <b>7:45 AM</b>	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Fell</b>	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Nursing Home</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4011 Randolph Rd. Wheaton Md</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John T. Parker</b>				29c. LICENSE NUMBER <b>P08546</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John T. Parker 8218 Wisconsin Ave Bethesda Md</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>				32. REGISTRAR'S SIGNATURE <b>John T. Parker</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

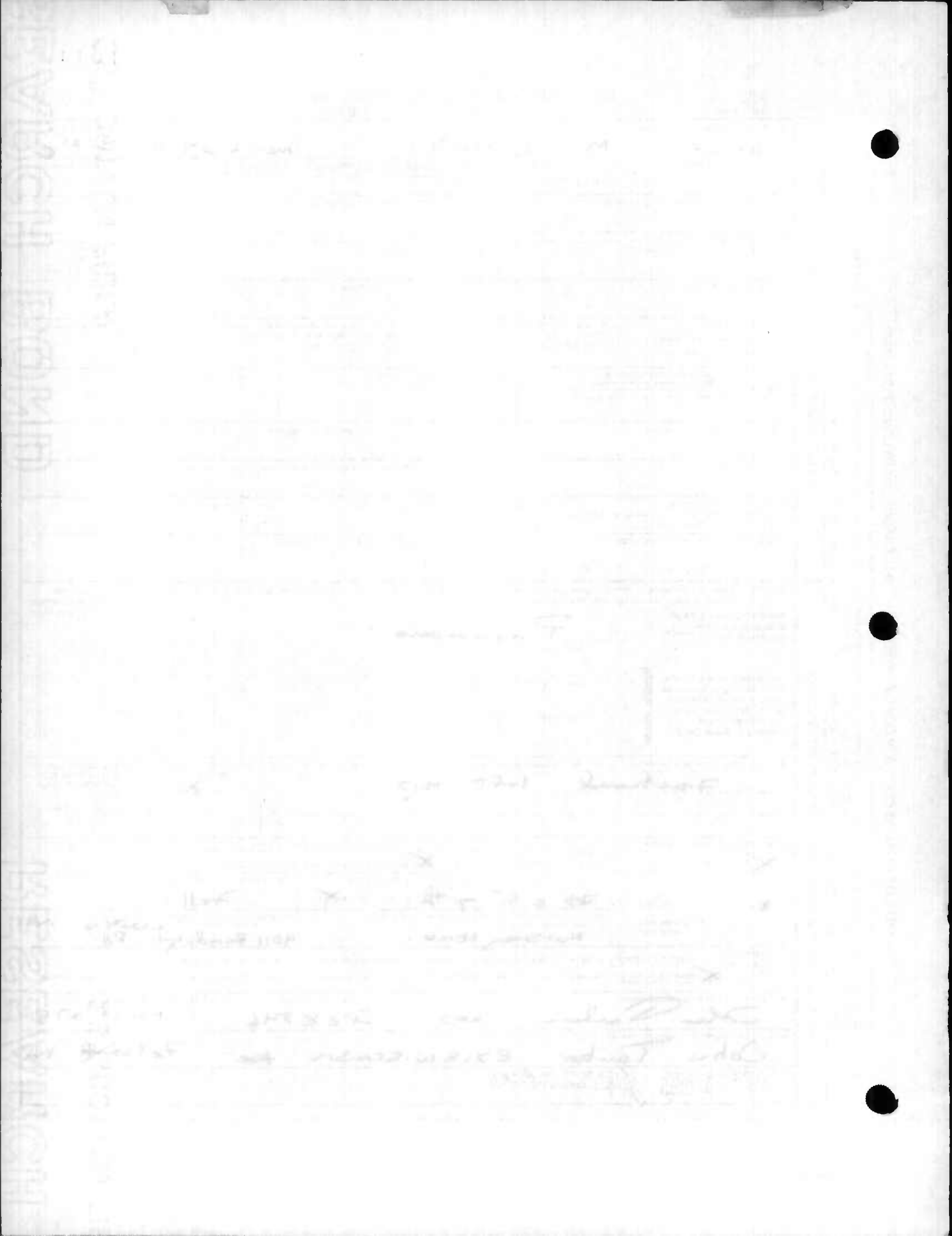
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11312

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Daisy Rosemond van Vliet				2. DATE OF DEATH MONTH DAY YEAR March 29 1995		3. TIME OF DEATH 5:30 A M	
4. SOCIAL SECURITY NUMBER 214-74-5872		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 5, 1898	
9a. FACILITY NAME (If not institution, give street and number) Lorien Nursing & Rehabilitation				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Fulton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11863 Scaggsville Road				10f. ZIP CODE 20759		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George Wilbur Bennett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeanette Catherine Hargett			
19a. INFORMANT'S NAME (Type/Print) Jeanette M. Horn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2911 Kensington Blvd. Kensington, Maryland 20895			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery 4/3/95		20c. LOCATION — City or Town, State Adelphi, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew J. Cole				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 3 Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal Bleeding							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard W. Smith M.D.				29c. LICENSE NUMBER D 25876		29d. DATE SIGNED (Month, Day, Year) March 29, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard W. Smith, M.D. 10802 Hickory Ridge Road Columbia, Maryland 21044							
31. DATE FILED (Month, Day, Year) MAR 30 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11313

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David Lee Wall</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>23</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:45 P M</i>	
4. SOCIAL SECURITY NUMBER 214 60 6924		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1951	
9a. FACILITY NAME (If not institution, give street and number) 5904 Johnson Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 5904 Johnson Avenue			
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>11</i> College (1-4 or 5+) <i>-</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Musician		16b. KIND OF BUSINESS/INDUSTRY Music			
17. FATHER'S NAME (First, Middle, Last) Charles Anderson Wall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Joyce Mills			
19a. INFORMANT'S NAME (Type/Print) Joyce M. Wall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Johnson Avenue, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. <i>March 25, 1995</i>		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00689		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute Pancreatitis</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <i>chronic alcoholism</i>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Paulsen MD</i>				29c. LICENSE NUMBER <i>D08546</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 23 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Paulsen 8218 Wisconsin Ave Bethesda</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 27 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11314

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Andre John Williams</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>22</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>021-20-8069</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 17, 1919</b>	
8a. FACILITY NAME (If not Institution, give street and number) <b>15107 Interlachen Drive, #817</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		8c. COUNTY OF DEATH <b>Montgomery</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>15107 Interlachen Drive, #817</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>Manager</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>International Business</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John E. Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Suzanne Merger</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gladys V. Williams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#817 15107 Interlachen Drive, Silver Spring, Maryland 20906</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Higgins</i> M00846				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1 month</b> <b>10 yrs - steady</b>							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>metastatic Uterine Disease</b> <b>Prostate Cancer</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ira P. Krefting</i>				29c. LICENSE NUMBER <b>071435</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 23, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ira P. Krefting, M.D., 2101 Medical Park Drive, Silver Spring, MD 20902</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11315

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Felix Romaro Wilson</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>21</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:39 P M</b>	
4. SOCIAL SECURITY NUMBER <b>800-08-1238</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 12, 1938</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Cuba</b>				9a. FACILITY NAME (If not institution, give street and number) <b>National Naval Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Cuba</b>		10b. COUNTY <b>Guantanamo Bay</b>	
10c. CITY, TOWN OR LOCATION <b>Guantanamo Bay</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>321 Marina Point, Box 43</b>	
10f. ZIP CODE <b>FPO Box AE 09593-0136</b>				10g. CITIZEN OF WHAT COUNTRY? <b>Cuban Exile</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Cuban</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self-employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant Manager</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Francisco Jose Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Padronela Romaro</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Paulina Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>U. S. Naval Base Cemetery</b>		20c. LOCATION — City or Town, State <b>4-1 Guantanamo Bay, Cuba</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Eileen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Anoxic Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Aortic Dissection Repair</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Transection of Aorta</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Multiple Injuries--severe</b>							Approximate Interval Between Onset and Death <b>4 days</b> <b>4 days</b> <b>26 days</b> <b>26 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>Feb. 23, 1995</b>		28b. TIME OF INJURY <b>9:30 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Single car accident</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Dominican Republic</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John F. Tauber</b>				29c. LICENSE NUMBER <b>208546</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 27-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John F. Tauber, M. D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11316

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rubin Waldman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 27 1995</b>				3. TIME OF DEATH <b>2 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>059-05-5725</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 21, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Russia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6121 Montrose Road</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Businessman</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Grocery</b>		
17. FATHER'S NAME (First, Middle, Last) <b>William Waldman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Molly Rubenstein</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Ivan Waldman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1001 Broadmore Circle Silver Spring MD 20904</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Lebanon</b>		DATE <b>3/29</b>		20c. LOCATION — City or Town, State <b>Adelphia MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Dysphagia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Parkinsons Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Dementia Cerebrovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. </b>									
Approximate Interval Between Onset and Death <b>6 years</b> <b>10+ years</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia Cerebrovascular Disease</b>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Steven Lipson MD</b>				29c. LICENSE NUMBER <b>D 05885</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Steven Lipson, MD 6121 Montrose Road Rockville MD</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 29 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11317

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marian R. Webster</b>				2. DATE OF DEATH <b>March 29, 1995</b> DAY MONTH YEAR		3. TIME OF DEATH <b>11:10 A</b> M	
4. SOCIAL SECURITY NUMBER <b>577-20-2052</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH <b>8-4-04</b> MONTH DAY YEAR	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LaPlata</b>		9c. COUNTY OF DEATH <b>Charles</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6303 Den Lee Drive</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Procurement Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hecht Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>J. Zac Webster</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Cooke</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edward B. Webster</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12733 Pearson Drive, Waldorf, Md 20602</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resurrection Cem. April 1, 1995</b>		20c. LOCATION — City or Town, State <b>Clinton, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles L. Belanger</b>				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, MD 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Acute Tubular Necrosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. DEHYDRATION &amp; INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death <b>1 MONTH</b> <b>1 week</b> <b>6 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MALNUTRITION</b> <b>REFUSAL TO EAT AND DRINK.</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>NA</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>AD. ATTENDING</b>				29c. LICENSE NUMBER <b>D44436</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASHVIN J PATEL MD 603 POST OFFICE RD #207 WALDORF MD 20602</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Dawson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11318

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte Lorraine				2. DATE OF DEATH MONTH April 3, DAY 1995 YEAR 1020 M			
4. SOCIAL SECURITY NUMBER 228-28-6856		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 26, 1911	
9a. FACILITY NAME (If not Institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland				10b. COUNTY Lusby		10c. CITY, TOWN OR LOCATION Lusby	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 11140 Cove Lake Road			
10f. ZIP CODE 20657				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Clayton Eugene Fleming				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mazie Bell			
19a. INFORMANT'S NAME (Type/Print) Doris L. Collins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11140 Cove Lake Road, Lusby, Maryland 20657			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Memorial Park Cem 3-6-95 DATE		20c. LOCATION — City or Town, State Falls Church, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE St. S. Smith				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6655 Old Alexander Ferry Road, Clinton, Maryland 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. ILEUS DUE TO (OR AS A CONSEQUENCE OF): d. INSTITUTIONAL COLON Approximate interval Between Onset and Death 5 days 5 days 2 weeks Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE, CHF, HTN, DM DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Summers				29c. LICENSE NUMBER D36969		29d. DATE SIGNED (Month, Day, Year) 4/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCARIA MATHEW MD 11910 H.G. TRUEMAN RD, LUSBY MD 20657							
31. DATE FILED (Month, Day, Year) APR 04 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

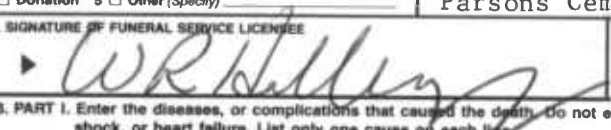
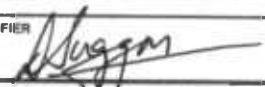
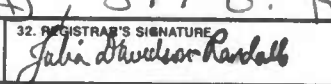
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11319

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT FRANCIS WHITE</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:53</b> a <input type="checkbox"/> M <input type="checkbox"/>	
4. SOCIAL SECURITY NUMBER <b>220-10-8108</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 24, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>615 N. Pinehurst Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>615 N. Pinehurst Ave.</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner/operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Marine Supplies</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Uriah Francis White</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nanna Kitzmiller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jane Hughes White</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 N. Pinehurst Ave., Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		DATE <b>3/28</b>		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiorespiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. metastatic Carcinoma - prostate</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>admission</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Carcinoma lung, congestive heart failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>A18614</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. Sagar MD, 517 G. Riverside Dr. Salisbury</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 28 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CLARA T. WHITE

95 11320

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARA ELIZABETH WHITE				2. DATE OF DEATH MONTH DAY YEAR March 22 1995		3. TIME OF DEATH 10:18 A M	
4. SOCIAL SECURITY NUMBER 219-14-4410		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) November 24, 1912		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Salisbury Nursing & Rehab Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, Md.		9c. COUNTY OF DEATH Wicomico	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4940 Nutters Cross Rd.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing aid		16b. KIND OF BUSINESS/INDUSTRY Hospital			
17. FATHER'S NAME (First, Middle, Last) George Tarleton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Catlin			
19a. INFORMANT'S NAME (Type/Print) Philip L. White				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4940 Nutters Cross Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens 3/25		20c. LOCATION — City or Town, State Hebron, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.R. Kelly Jr.</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary artery disease</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Serum</i> c. <i>Heart insufficiency</i> d. <i>Heart insufficiency</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W.R. Kelly Jr.</i>				29c. LICENSE NUMBER D---29349		29d. DATE SIGNED (Month, Day, Year) 3/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) MAR 27 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11321

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Adam F. Wisniewski				2. DATE OF DEATH MONTH DAY YEAR 03/ 19/ 1995		3. TIME OF DEATH 2330 M	
4. SOCIAL SECURITY NUMBER 221-09-4290		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 23, 1912	
8. BIRTHPLACE (State or Foreign Country) Wilmington, DE.				9. FACILITY NAME (If not institution, give street and number) Atlantic General Hospital		10. CITY, TOWN OR LOCATION OF DEATH Berlin	
11. RESIDENCE OF DECEDENT				12. COUNTY New Castle		13. CITY, TOWN OR LOCATION Wilmington	
14. STATE Delaware		15. STREET AND NUMBER 1508 Linden Street		16. ZIP CODE 19805		17. CITIZEN OF WHAT COUNTRY? USA	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: White	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		24. KIND OF BUSINESS/INDUSTRY Bridge Authority			
25. FATHER'S NAME (First, Middle, Last) Vincent Wisniewski				26. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Drejka			
27. INFORMANT'S NAME (Type/Print) Anna Wisniewski				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Linden St. Wilmington, DE. 19805			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cathedral Cemetery		31. DATE 3/24/95		32. LOCATION — City or Town, State Wilmington, DE.	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE 				34. NAME AND ADDRESS OF FACILITY Parsell, Atkins & Lodge Funeral Home, Inc. P.O. Box 477 Lewes, DE. 19958			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CAD, pul. edema</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						35. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						37. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
38. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY M		41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				43. DESCRIBE HOW INJURY OCCURRED			
44. LOCATION (Street and Number or Rural Route Number, City or Town, State)				45. DATE SIGNED (Month, Day, Year) 3/20/95			
46. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
47. SIGNATURE AND TITLE OF CERTIFIER 				48. LICENSE NUMBER D43561		49. DATE SIGNED (Month, Day, Year) 3/20/95	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAAD - Eldin Bedeir MD Atlantic General Hosp Berlin MD 21811							
51. DATE FILED (Month, Day, Year) MAR 23 1995		52. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11322

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CORA FARLOW WRIGHT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 20 1995</b>		3. TIME OF DEATH <b>1345</b> M	
4. SOCIAL SECURITY NUMBER <b>164-03-7689</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 15, 1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Waterview Health Care Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>612 Douglas Rd.</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>George L. Farlow</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Rickards</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Farlow</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 Douglas Rd., Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington Cemetery 3/24</b>			
20c. LOCATION — City or Town, State <b>Drexel Hill, PA</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>WR</i>			
22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Aortic STENOSIS</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M</b> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas C. Hill Jr. Medical Director</b>			
29c. LICENSE NUMBER <b>D 08008</b>				29d. DATE SIGNED (Month, Day, Year) <b>03-20-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas C. Hill Jr. 108 Pine Bluff Rd. Salisbury Md 21801</b>				31. DATE FILED (Month, Day, Year) <b>MAR 22 1995</b>			
32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11323

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Roy A. Watson</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>20</b> YEAR <b>95</b>				3. TIME OF DEATH <b>0727</b> M			
4. SOCIAL SECURITY NUMBER <b>221-10-1904</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-18-15</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Peninsula Regional Medical Ctr</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>				9c. COUNTY OF DEATH <b>Wicomico</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Girdletree</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5507 Onley Rd.</b>				10f. ZIP CODE <b>21829</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waterman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Seafood</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Warrie L Watson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beulah Mumford</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Kathleen S. Watson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5507 Onley Rd., Girdletree, MD 21829</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		DATE <b>3/21</b>		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Bulkeley</i>				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>years</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></b>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Bulkeley, M.D.</i> <b>D.M.E.</b>				29c. LICENSE NUMBER <b>D03599</b>		29d. DATE SIGNED (Month, Day, Year) <b>03-20-95</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John T. Bulkeley, M.D., 108 Pine Bluff Road, Salisbury, MD 21801</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 22 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


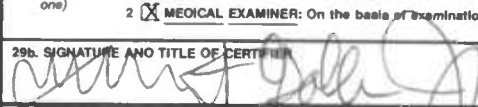
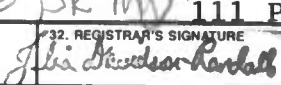
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>BRIAN Keith WARD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 25 1995</b>		3. TIME OF DEATH <b>7:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-94-0619</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>17</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 27, 1978</b>	
8a. FACILITY NAME (If not Institution, give street and number) <b>MEMORIAL HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		8c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Oakland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>126 Bray School Road</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Student</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		16b. KIND OF BUSINESS/INDUSTRY <b>High School</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Leroy Ward</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Shirley Jane Welch</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ronnie M. Welch</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>126 Bray School Road, Oakland, Maryland 21550</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrett Co. Mem. Gardens 3/28</b>		20c. LOCATION — City or Town, State <b>Oakland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 32 S. Second St., Oakland, MD 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Approximate interval between Onset and Death</b> <b>Sudden</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>3/24/95</b>		28b. TIME OF INJURY <b>4:15 P M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>COLLISION DRIVER AUTO VS FIXED OBJECT</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>OAKLAND SANG-RUN RD, OAKLAND MD</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 26, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE, JR. MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 30 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11325

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Betty Jean Winston				2. DATE OF DEATH MONTH DAY YEAR 3/31/1995		3. TIME OF DEATH 4:35 AM	
4. SOCIAL SECURITY NUMBER 217-42-4275		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 2 1942	
9a. FACILITY NAME (If not institution, give street and number) 12502 Morano Dr.				9b. CITY, TOWN OR LOCATION OF DEATH Brandywine		9c. COUNTY OF DEATH Prince George's	
10a. STATE MD				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Port Tobacco	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8962 Chapel Pt. Rd.		10f. ZIP CODE 20677	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Store Clerk		16b. KIND OF BUSINESS/INDUSTRY Convenience Store	
17. FATHER'S NAME (First, Middle, Last) Fred Bryant				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertie Lee Gordon Covey			
19a. INFORMANT'S NAME (Type/Print) William E. Winston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 South Island Square Dr. St. Simons Island, GA 31522			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Mem. Gardens 4/3/95		20c. LOCATION — City or Town, State Waldorf, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Edwards				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cervical adenocarcinoma cell cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Karl-Yu Yeh				29c. LICENSE NUMBER D04230		29d. DATE SIGNED (Month, Day, Year) 3-31-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karl-Yu Yeh 8926 Woodyard Rd Clinton MD 20735							
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

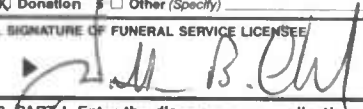

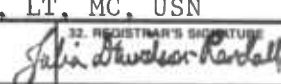




95 11326

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH WINSTON WADE				2. DATE OF DEATH MONTH DAY YEAR MAR 29 1995		3. TIME OF DEATH P M 12:45	
4. SOCIAL SECURITY NUMBER 430-20-3005		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 17, 1923	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Virginia				10b. COUNTY Fairfax		10c. CITY, TOWN OR LOCATION Fairfax	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3908 Sablewood Court				10f. ZIP CODE 22030		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Navy, July 1943-Aug 1970		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commissioned Officer		16b. KIND OF BUSINESS/INDUSTRY U.S. Navy			
17. FATHER'S NAME (First, Middle, Last) Barnie Wade				18. MOTHER'S NAME (First, Middle, Maiden Surname) Miriam Crump			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Fielder (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Honey Locust Ct, Fairfax, VA 22033			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) U.S.U.H.S.		DATE 3-30		20c. LOCATION — City or Town, State Bethesda, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. METASTATIC PROSTATE CANCER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 14 days 4 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  LT MC, USN				29c. LICENSE NUMBER 0101051813 (VA)		29d. DATE SIGNED (Month, Day, Year) 03/30/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BROOKS D. CASH, LT, MC, USN				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600			
31. DATE FILED (Month, Day, Year) MAR 31 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

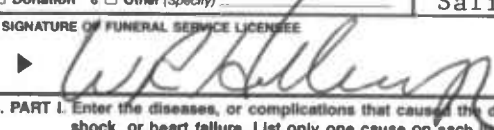
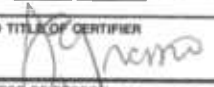
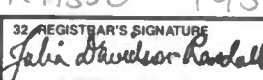
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11327

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET COLLINS YOW				2. DATE OF DEATH MONTH DAY YEAR March 21, 1995		3. TIME OF DEATH 9:54 a.m.	
4. SOCIAL SECURITY NUMBER 455-32-2372		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 30, 1925	
9a. FACILITY NAME (If not institution, give street and number) 669 North Park Dr.				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 669 North Park Dr.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Norman Gideon Collins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Johanna Niemoeller			
19a. INFORMANT'S NAME (Type/Print) Margaret Y. Scott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2448 Indian Ct., Waldorf, MD 20601			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State Salisbury, MD 21801		20d. DATE 3/22	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic Colon Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 20507		29d. DATE SIGNED (Month, Day, Year) 3/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph A. GRASSO 145 E. CARROLL ST SALISBURY MD							
31. DATE FILED (Month, Day, Year) MAR 22 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11328

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nancy Dooley Yeatman				2. DATE OF DEATH MONTH DAY YEAR March 26, 1995				3. TIME OF DEATH 10:15 P M			
4. SOCIAL SECURITY NUMBER 021-32-9945		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 12, 1940		8. BIRTHPLACE (State or Foreign Country) Massachusetts			
9a. FACILITY NAME (If not institution, give street and number) 4836 Flower Valley Drive				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4836 Flower Valley Drive				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Edward Joseph Dooley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa O'Brien							
19a. INFORMANT'S NAME (Type/Print) Francis E. Yeatman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4836 Flower Valley Drive Rockville, Maryland 20853							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 3/30/95 Silver Spring, Maryland		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): 2 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Metastatic Esophageal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): 1 year c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER VA29340		29d. DATE SIGNED (Month, Day, Year) 3/28/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Meister, M.D. 1715 N. GEO. MASON DR. ARL, Va. 22205											
31. DATE FILED (Month, Day, Year) MAR 29 1995		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11329

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marie F. Yeager</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>27</i> YEAR <i>95</i>		3. TIME OF DEATH <i>7:57 P</i>	
4. SOCIAL SECURITY NUMBER <i>579-40-4697</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>MAY 4, 1917</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>HOLY CROSS HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SILVER SPRING</i>		9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD.</i>		10b. COUNTY <i>MONTGOMERY</i>		10c. CITY, TOWN OR LOCATION <i>SILVER SPRING</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4405 CLEARFIELD RD.</i>				10f. ZIP CODE <i>20906</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3</i> College (1-4 or 8+) <i>3</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>REGISTERED NURSE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>NURSING</i>			
17. FATHER'S NAME (First, Middle, Last) <i>CORNELIUS SCHWARZ</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>CAROLINE BRENNER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>NORA B. YEAGER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>SAME AS ITEM #10</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>PARKLAWN CEMETERY</i>		DATE <i>3/31</i>		20c. LOCATION — City or Town, State <i>ROCKVILLE, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> MO0091				22. NAME AND ADDRESS OF FACILITY <i>W. W. CHAMBERS CO. INC., SILVER SPRING, MD.</i> 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Tamponade</i> DUE TO (OR AS A CONSEQUENCE OF): <i>mediastinal hematoma</i> DUE TO (OR AS A CONSEQUENCE OF): <i>attempted placement of</i> DUE TO (OR AS A CONSEQUENCE OF): <i>permanent pacemaker</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tamber</i>				29c. LICENSE NUMBER <i>D08546</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 27 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Tamber 8218 Wisconsin Ave Bethesda MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 30 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Tamber</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


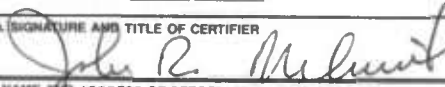
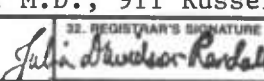
CC



95 11330

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Leonard ZINSER</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:45 p. M</b>	
4. SOCIAL SECURITY NUMBER <b>216-01-5575</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 12, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
10. FACILITY NAME (If not institution, give street and number) <b>403 Russell Avenue Apt. #108</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>		12. COUNTY OF DEATH <b>Montgomery</b>	
13. STATE <b>Maryland</b>		14. COUNTY <b>Montgomery</b>		15. CITY, TOWN OR LOCATION <b>Gaithersburg</b>		16. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
17. STREET AND NUMBER <b>403 Russell Avenue Apt. #108</b>				18. ZIP CODE <b>20877</b>		19. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
20. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrician</b>		26. KIND OF BUSINESS/INDUSTRY <b>City of Baltimore Department of Education</b>			
27. FATHER'S NAME (First, Middle, Last) <b>Herman Zinser</b>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelia Greenwald</b>			
29. INFORMANT'S NAME (Type/Print) <b>Lillian M. Zinser</b>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 Russell Ave., Apt. #108, Gaithersburg, MD 20877</b>			
31. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		33. DATE <b>3/30</b>		34. LOCATION — City or Town, State <b>Alexandria, Virginia</b>	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE 				36. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr., Gaithersburg, MD 20877</b>			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. malignant abdominal mesothelioma</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>2 months</b>	
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						39. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
41. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		42. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
43. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		44. DATE OF INJURY (Month, Day, Year)		45. TIME OF INJURY <b>M</b>		46. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		48. DESCRIBE HOW INJURY OCCURRED					
49. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
50. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. SIGNATURE AND TITLE OF CERTIFIER 				52. LICENSE NUMBER <b>D19294</b>		53. DATE SIGNED (Month, Day, Year) <b>March 29, 1995</b>	
54. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John R. Melnick, M.D., 911 Russell Avenue, Gaithersburg, Maryland 20877</b>							
55. DATE FILED (Month, Day, Year) <b>MAR 31 1995</b>		56. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

15

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11331

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Regina Marie Ashton				2. DATE OF DEATH MONTH DAY YEAR 04 09 95		3. TIME OF DEATH 12:20 A.M.	
4. SOCIAL SECURITY NUMBER 225-86-1211		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 8, 1956	
9a. FACILITY NAME (If not institution, give street and number) 3210 LaDova Way				9b. CITY, TOWN OR LOCATION OF DEATH Landover		9c. COUNTY OF DEATH P.G.	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION :Landover		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3210 LaDova Way				10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Technician		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Andrew Ashton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cindy Ashton Tolson			
19a. INFORMANT'S NAME (Type/Print) Mary Ashton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 LaDova Way Landover, MD. 20785			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Pk. 4/15/95		20c. LOCATION - City or Town, State Landover, Md.		20d. DATE 4/15/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorice Edwards				22. NAME AND ADDRESS OF FACILITY Hodges and Edwards 3910 Silver Hill Rd. Suitland, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stage 4 Primary Lung Adeno-Carcinoma Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. With Brain and Bone Metastasis c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dal Yoo MD.				29c. LICENSE NUMBER 4360		29d. DATE SIGNED (Month, Day, Year) 04-10-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dal Yoo MD. 1160 Varnum St. N.E. Wash. D.C.							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11332

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>CHARLOTTE E. ANDERSON</del> Charlotte Edith Anderson				2. DATE OF DEATH MONTH DAY YEAR APRIL 9 1995		3. TIME OF DEATH 5:55 P. M.	
4. SOCIAL SECURITY NUMBER 577.52.3531		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-11-1930	
9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CTR.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8 SOUTH MEADOW DRIVE				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE		16b. KIND OF BUSINESS/INDUSTRY NORTH ARUNDEL HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) CHARLES HORNER YOUNKIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAGDALENE EDITH BOLDEN			
19a. INFORMANT'S NAME (Type/Print) BENJAMIN W. ANDERSON JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 SOUTH MEADOW DRIVE GLEN BURNIE, MARYLAND 21060			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE INC. 4-12		20c. LOCATION — City or Town, State TOWSON, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD. 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. LIVER CELL FAILURE DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval between Onset and Death 1 MONTH
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. METASTATIC ADENOCARCINOMA OF THE BREAST DUE TO (OR AS A CONSEQUENCE OF):					5 YEARS
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thab Gu. Wahba, M.D., house officer				29c. LICENSE NUMBER AS 2441614-26		29d. DATE SIGNED (Month, Day, Year) APRIL 9 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IHAB M. WAHBA 3001 SOUTH HANOVER ST. BALTIMORE, MD 21225							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

30

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2045-510  
FOR  
CIP 1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <del>SHATONE</del> Shaton BLAKE				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 9:24 A M	
4. SOCIAL SECURITY NUMBER N/A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 3 1/2 MOS. YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 29, 1994	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) SAINT AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2527 EDMONDSON <del>STREET</del> Ave	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) KENNETH L. BLAKE				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORTINNA WAKER			
19a. INFORMANT'S NAME (Type/Print) CORTINNA WAKER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 EDMONDSON AVENUE, BALTIMORE, MD. 21223			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 4-14-95		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPHYXIA BY OVERLAYING DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-10-95		28b. TIME OF INJURY 8:56 A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS ACCIDENTALLY LAID ON		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MD.		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIE JR MD 111 PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11334

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George Beckett</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>6</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212 14 1035</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-24-17</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>na</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1701 Eutaw Place #425</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Hypertension</b> Approximate Interval Between Onset and Death <b>minutes</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. Khokhar MD</b>				29c. LICENSE NUMBER <b>D32700</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Anwar Islam Khokhar, M.D. c/o Maryland General Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11335

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen J Borgmeier				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 8:10 P M	
4. SOCIAL SECURITY NUMBER 216-16-4405		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 25, 1901	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2721 Wells Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Edgemere	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Edgemere				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2721 Wells Avenue	
10f. ZIP CODE 21219				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 8+) 6 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Operator		16b. KIND OF BUSINESS/INDUSTRY Communications	
17. FATHER'S NAME (First, Middle, Last) John U. Janssen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine A. Magsamen			
19a. INFORMANT'S NAME (Type/Print) Bettie E. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2721 Wells Avenue Edgemere, MD 21219			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Most				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 4/13/95		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gregory E. Reed				22. NAME AND ADDRESS OF FACILITY Duda-Ruch Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Ventricular Arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death immediate 10 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John J. Reed MD				29c. LICENSE NUMBER D30555		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2566 North Point Rd Balto MD 21219							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE John J. Reed			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>PAULINE</u> <u>BLATCHLEY</u>				2. DATE OF DEATH MONTH <u>APRIL</u> DAY <u>11</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>6:08 P M</u>	
4. SOCIAL SECURITY NUMBER <u>216-01-6008</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>90</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>July 21, 1904</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Good Samaritan Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>1422 Walker Avenue</u>			
10f. ZIP CODE <u>21239</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Sales Person</u>		16. KIND OF BUSINESS/INDUSTRY <u>Retail Department Store</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Richard C Emerick</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Pauline G Meeks</u>			
19a. INFORMANT'S NAME (Type/Print) <u>W.C. Blatchley Jr</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13005 Purdum Ct., Mt. Airey, Maryland 21771</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		20c. LOCATION — City or Town, State <u>4/14 Baltimore, Maryland</u>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>George Ferrante</u>				22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road Baltimore, Maryland 21212</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>STROKE</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <u>1 DAY</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>MYOCARDIAL INFARCTION;</u> <u>RENAL FAILURE; CONGESTIVE HEART FAILURE</u> <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Maya Gupta</u>				29c. LICENSE NUMBER <u>108236</u>		29d. DATE SIGNED (Month, Day, Year) <u>04/11/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MAYA GUPTA</u> <u>GOOD SAMARITAN HOSPITAL</u>							
31. DATE FILED (Month, Day, Year) <u>APR 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Stewison Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11337

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>OLIVIA MARGARET CLARKE</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:00am</b> M	
4. SOCIAL SECURITY NUMBER <b>203-32-0554</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH MONTH <b>JAN</b> DAY <b>19</b> YEAR <b>1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>7700 York Road</b>			
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>Canada</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Apartment Complex</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frederick Joseph Clarke</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Swanton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert A. Clarke</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17121 Whites Rd. Poolesville, MD 20837-2236</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/12/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b> 				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PSEUDOMEMBRANOUS COLITIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ANTIBIOTIC THERAPY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>DAYS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PULMONARY EDEMA</b> <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER 
29c. LICENSE NUMBER <b>D13140</b>							29d. DATE SIGNED (Month, Day, Year) <b>APRIL 11, 1995</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>REYNALDO ORJUELA-GOMEZ, MD, ST. JOSEPH MEDICAL CENTER, TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11338

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Monrales Charlton</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>3:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-62-6429</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 20, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LEVINDALE HEBREW GERIATRIC CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3747 COLUMBUS DRIVE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELECTRICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>COPPERS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALPHANSO CHARLTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SUSAN (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARJORIE WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2810 SANTA FA AVENUE BALTIMORE, MARYLAND 21215</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY 4-15-95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>CALVIN L. WILLIAMS F.S. 270 FREDHILTON PASS BALTO., MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ISCHEMIA OF LOWER EXTREMITIES</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>MIN</b> <b>DAYS</b> <b>WKS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DECUBITUS, HYPERTENSION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Matthew K. McNabney MD</i>		29c. LICENSE NUMBER <b>D45757</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MATTHEW MCNABNEY 2434 W. BELVEDERE BALTO, MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11339

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STANLEY L CAHN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 9 1995</b>		3. TIME OF DEATH <b>5:00A</b>	
4. SOCIAL SECURITY NUMBER <b>213-09-8821</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 28, 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>KESWICK NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>50 BOUTON GREEN (CROSS KEYS)</b>			
10f. ZIP CODE <b>21210</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PROPRIETOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ADVERTISING AGENCY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES CAHN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDNA BERLINER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY JANE CAHN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>50 BOUTON GREEN, BALTO., MD. 21210</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW, BELAIR RD. 4/11/95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Parkinson's Disease</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>212437</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-9-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Hunter Wilson 4 W. University Pkwy Baltimore, MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11340

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Gloria Cimino				2. DATE OF DEATH MONTH: April DAY: 10 YEAR: 1995		3. TIME OF DEATH 7:55 p.m.	
4. SOCIAL SECURITY NUMBER 212-03-8875		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 12, 1901		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2300 Dulaney Valley Rd.		10f. ZIP CODE 21204	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Tobacco (French Government)	
17. FATHER'S NAME (First, Middle, Last) Charles Colimore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Fava			
19a. INFORMANT'S NAME (Type/Print) James Albert Colimore, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Jamieson Rd., Lutherville, MD 21093			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum 4/12		20c. LOCATION — City or Town, State Timonium, MD 21093	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lowell M. Lemmon</i>				22. NAME AND ADDRESS OF FACILITY X Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary heart failure</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Myocardial infarction</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER 15504		29d. DATE SIGNED (Month, Day, Year) 4-11-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. J. AGED 45 2300 Dulaney Valley Rd 21204							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Constance NMN Cory				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 9:00 P. M	
4. SOCIAL SECURITY NUMBER 214-26-9350		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 12, 1912	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center-Randallstown				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Randallstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9109 Liberty Road				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown		16b. KIND OF BUSINESS/INDUSTRY Unknown			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Carl R. Gold, Esquire				19b. MAILING ADDRESS (Name of town, city or town, state, zip code) 406 W. Allegheny Avenue, Towson, Maryland 21204			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place) Baldwin Memorial Church Cemetery		20c. DATE 4/13/95		20d. LOCATION — City or Town, State Millersville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 25 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Chronic upper GI bleeding DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Jerome H. Ginsberg, M.D.		29c. LICENSE NUMBER D20964		29d. DATE SIGNED (Month, Day, Year) April 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133							
31. DATE FILED (Month, Day, Year) APR 13 1995		32. REGISTRAR'S SIGNATURE Julia Stivers-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11342

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

April 8

1. DECEDENT'S NAME (First, Middle, Last) James Alford DOWELL				2. DATE OF DEATH APR 8, 1995		3. TIME OF DEATH 10:08A	
4. SOCIAL SECURITY NUMBER 219 05 0508		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEP 10 1920	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE	
9c. COUNTY OF DEATH BALTIMORE COUNTY				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION GLN ARM				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER BOX 224 GLN ARM ROAD	
10f. ZIP CODE 21057				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YRS College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY Electrician	
17. FATHER'S NAME (First, Middle, Last) Raymond Dowell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Finkenginder			
19a. INFORMANT'S NAME (Type/Print) GARY R. Dowell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 CONTENT LANE REISTERSTOWN, MARYLAND 21736			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY 4-11		20c. LOCATION — City or Town, State PARKVILLE MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIALS 8500 HARFORD ROAD - PARKVILLE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardio Renal</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Vascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29b. LICENSE NUMBER D 09383		29c. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. Dowell MD - 408 Maple Avenue - 111 N. Market Hall Rd							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11343

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROY ALLEN EILERS</b>				2. DATE OF DEATH DAY <b>6</b> YEAR <b>1995</b> MONTH <b>11</b> P.M.				3. TIME OF DEATH <b>11:00 P</b>					
4. SOCIAL SECURITY NUMBER <b>213 54 1306</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 10, 1949</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>60 MISTY WOOD CIRCLE</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Timonium</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>Timonium</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>60 MISTY WOOD CIRCLE</b>						10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b> College (1-4 or 5+) <b>1 YR</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MECHANIC ASSEMBLER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>TECH AID</b>					
17. FATHER'S NAME (First, Middle, Last) <b>FRANCIS J. EILERS</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GERTRUDE KRESMENT</b>							
19a. INFORMANT'S NAME (Type/Print) <b>FRANCIS J. EILERS</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>134 MISTY WOOD CIRCLE Timonium, MARYLAND 21093</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEMORIAL 4-10-95</b>				20c. LOCATION — City or Town, State <b>Timonium, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>						22. NAME AND ADDRESS OF FACILITY <b>EVANS CHARLES OF CHIMES 2325 YORK ROAD - Timonium</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardio Renal Vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles F. O'Donnell MD</b>				29c. LICENSE NUMBER <b>D-09383</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell MD - 408 North House - 111 Hamlet Hill</b>													
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11344

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES KATHRYN ELGIN				2. DATE OF DEATH MONTH April 11, DAY 1995 YEAR		3. TIME OF DEATH 7 P. M	
4. SOCIAL SECURITY NUMBER 212-16-4059		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 8, 1909	
8. BIRTHPLACE (State or Foreign Country) Reisterstown, Md.				9a. FACILITY NAME (If not institution, give street and number) 110 First Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Reisterstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 110 First Ave.	
10f. ZIP CODE 21136				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) High School College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) State Highway Dept.		16b. KIND OF BUSINESS/INDUSTRY Secretary	
17. FATHER'S NAME (First, Middle, Last) William I. Stevenson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Becker			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Diane Channell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Pinedale Drive Baltimore, Md. 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Memorial Gardens		20c. LOCATION — City or Town, State Finksburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sam B. Elmer</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, Md. 21136			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>Immediate</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Moss</i>				29c. LICENSE NUMBER <i>032002</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/12/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Moss M. D. 114 Business Center Dr. Reisterstown, Md. 21136							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>Julia A. Hurdle-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11345

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CORA STIRN FEELEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr 10, 1995</b>		3. TIME OF DEATH <b>2 A. M</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-4343</b>		5. SEX <b>M</b>		6. AGE (In yrs. last birthday) <b>100 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Sep 4, 1894</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Lutherville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1511 Pickett Road</b>	
10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+) <b>At home</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>John H. Stirn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherina Sporleder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Francis M. Feeley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1511 Pickett Road, Lutherville, MD 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley M. G. 4/13/95 Timonium, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles F. Evans, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Evans Chapel of Chimes 2325 York Road</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRO VASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>INFECTED ULCER</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. DATE SIGNED (Month, Day, Year) <b>4.11.95</b>	
29a. SIGNATURE AND TITLE OF CERTIFIER		29b. LICENSE NUMBER <b>15504</b>		29c. DATE SIGNED (Month, Day, Year)		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E. W. Roberts MD 2300 Pickett Rd 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>J. A. Duckworth</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6/12

1. Name of the person  
2. Address  
3. City

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



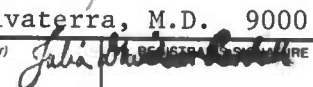
MADE IN U.S.A. 1944



95 11346

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lela Bell Fink</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214 20 0350</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 25 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Sq. Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>720 Seneca Park Rd.</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/9 (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Boyles</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Dunlap</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Vincent C. Fink</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 Seneca Park Rd. Baltimore, MD 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of funerary home, cemetery, etc.) <b>Bel Air Memorial Gardens</b>		20c. DATE <b>4/13/95</b>		20d. LOCATION — City or Town, State <b>Bel Air, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FUNERAL HOME <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Balto., MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Acute respiratory acidosis</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Weakness due to infection</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Lung and breast cancer</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death <b>24 hours</b> <b>24 hours</b> <b>8 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D74566</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-12-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carmen Salvaterra, M.D. 9000 Franklins Square Drive Baltimore, MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b> 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANTHONY FAIR</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>8</b> , 1995 YEAR		3. TIME OF DEATH <b>10:4</b>	
4. SOCIAL SECURITY NUMBER <b>218-52-3529</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-12-49</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>na</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>401 E. Eager Street</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Disabled Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Various Trades</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Fair</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eva Anderson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5559 Lawrence Street Baltimore, MD. 21217</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Cemetery 4-12-95 Baltimore, MD.</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD.</b>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St., Balto, MD 21201</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St., Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Acute Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>1 week</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 weeks</b>	
		c. <b>Acquired Immunodeficiency Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 years</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>James A. Underwood</b>		29c. LICENSE NUMBER <b>M6175</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Underwood, M.D., Johns Hopkins Hospital, Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>Ronald Wade</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11348

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Arthur Nathaniel Fletcher</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 9, 1995</b>		3. TIME OF DEATH <b>8:10 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>705-12-1785</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 19, 1905</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>82 Winters Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>82 Winters Lane</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>9th GRADE</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Track Foreman</b>		15b. KIND OF BUSINESS/INDUSTRY <b>B &amp; O Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward Fletcher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alverta</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mabel C. Fletcher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>82 Winters Lane Catonsville, Maryland 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 4/14/95</b>		20c. LOCATION — City or Town, State <b>Arbutus, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Geray Harris</i>				22. NAME AND ADDRESS OF FACILITY <b>5240 Reisterstown Road Baltimore, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Ischemic Cardiac myopathy</b> <b>Arteriosclerosis</b> <b>High blood pressure</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alexandro</i>				29c. LICENSE NUMBER <b>DO 8780</b>		29d. DATE SIGNED (Month, Day, Year) <b>9/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALEXANDRO MARIA M.D. 405 Frederick Rd Balto 21228</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Russell</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

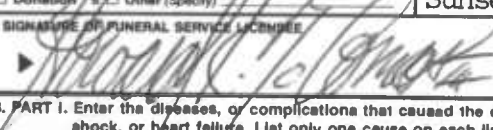
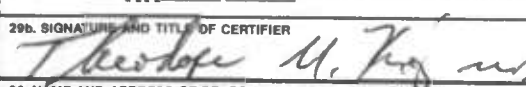

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAMIN HOMER LEE GOWAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 10, 1995</b>		3. TIME OF DEATH <b>01:32 A M</b>					
4. SOCIAL SECURITY NUMBER <b>247-02-9533</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>43</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 12, 1951</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>1918 HIGH POINT RD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Forest Hill</b>		9c. COUNTY OF DEATH <b>HARFORD</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Forest Hill</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1918 High Point Road</b>				10f. ZIP CODE <b>21050</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plant Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Snack Food Manufacturing</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Curtis Earl Gowan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne Pauline Wright</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Darlene B. Gowan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1918 High Point Road, Forest Hill, Maryland 21050</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park 4/13/95</b>		20c. LOCATION — City or Town, State <b>Forest City, N.C.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PULMONARY THROMBOEMBOLISM</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DEEP VEIN THROMBOSIS COMPLICATING THIGH INJURY</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d. _____</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>POLIO</b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 4-10-95</b>		28b. TIME OF INJURY <b>12:20 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INJURED LEG</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 10, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING 111 PENN STREET BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11350

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ADELAIDE C. HARNER</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:20 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-12-0363</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-28-24</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7700 Old Harford Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Parkville</b>		9c. COUNTY OF DEATH <b>Balto. County</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Parkville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7700 Old Harford Road</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Yrs.</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>At home</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSEWIFE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Crismer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Adelaide Miller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edmund G. Harner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7700 Old Harford Road, Balto., MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 4-14-95 Parkville</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL HOME LICENSEE  <b>Charles E. Evans, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Evans Funeral Chapel 8800 Harford Road, Balto., MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cholangiocarcinoma &amp; Metastasis to liver.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Ascaris</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Joseph C. Lin, M.D.</b>				29c. LICENSE NUMBER <b>D 27670</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph C. Lin, M.D., 8803 Harford Rd., Baltimore Md. 21234</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b> REGISTRAR'S SIGNATURE							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11351

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John William Henry Jr.</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>9</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>6:00 P.</i> M	
4. SOCIAL SECURITY NUMBER <i>218 08 0764</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>12</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>April 20, 1982 Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Franklin Square Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rossville 21237</i>		9c. COUNTY OF DEATH <i>BALTIMORE</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Middle River</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1515 Becklow Avenue</i>				10f. ZIP CODE <i>21220</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Student</i>		16b. KIND OF BUSINESS/INDUSTRY <i>School</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John William Henry, Sr.</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Dina Norman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Dallas Norman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>913 Lance Avenue Baltimore, Maryland 21221</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holly Hill Mem Gardens 4/13/95</i>		20c. LOCATION — City or Town, State <i>Baltimore County, Md</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Bruzdinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden Death</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i></i> b. <i></i> c. <i></i> d. <i></i>							Approximate interval Between Onset and Death <i>5 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i></i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stacy Z. [Signature]</i>				29c. LICENSE NUMBER <i>001085</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 9, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stacy Z. [Signature] 35 Judges Lane 21200</i>							
31. DATE FILED (Month, Day, Year) <i>APR 18 1995</i>				32. REGISTRAR SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11352

ITEM: 3. PER DR. FILM G-723 5/2/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ernest O. Henson</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>6</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:22 PM</b>	
4. SOCIAL SECURITY NUMBER <b>085-07-9547</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-27-09</b>	
6a. FACILITY NAME (If not institution, give street and number) <b>1701 Eutaw Place</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1701 Eutaw Place</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6 th</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Inspector</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph C. Henson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha V. Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Raymarlyn Jenkins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3016 Parkside Drive Balto., Md. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. LOCATION — City or Town, State <b>4-13 Woodlawn, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Derrick C. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 15</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pulmonary edema</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>heart failure</b> <b>laryngeal cancer</b> <b>prostate cancer</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>laryngeal cancer</b> <b>prostate cancer</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee M. Krug M.D.</i>				29c. LICENSE NUMBER <b>MG302</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lee M. Krug M.D. Johns Hopkins Hosp, 110 Tower Balt. MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>J. H. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

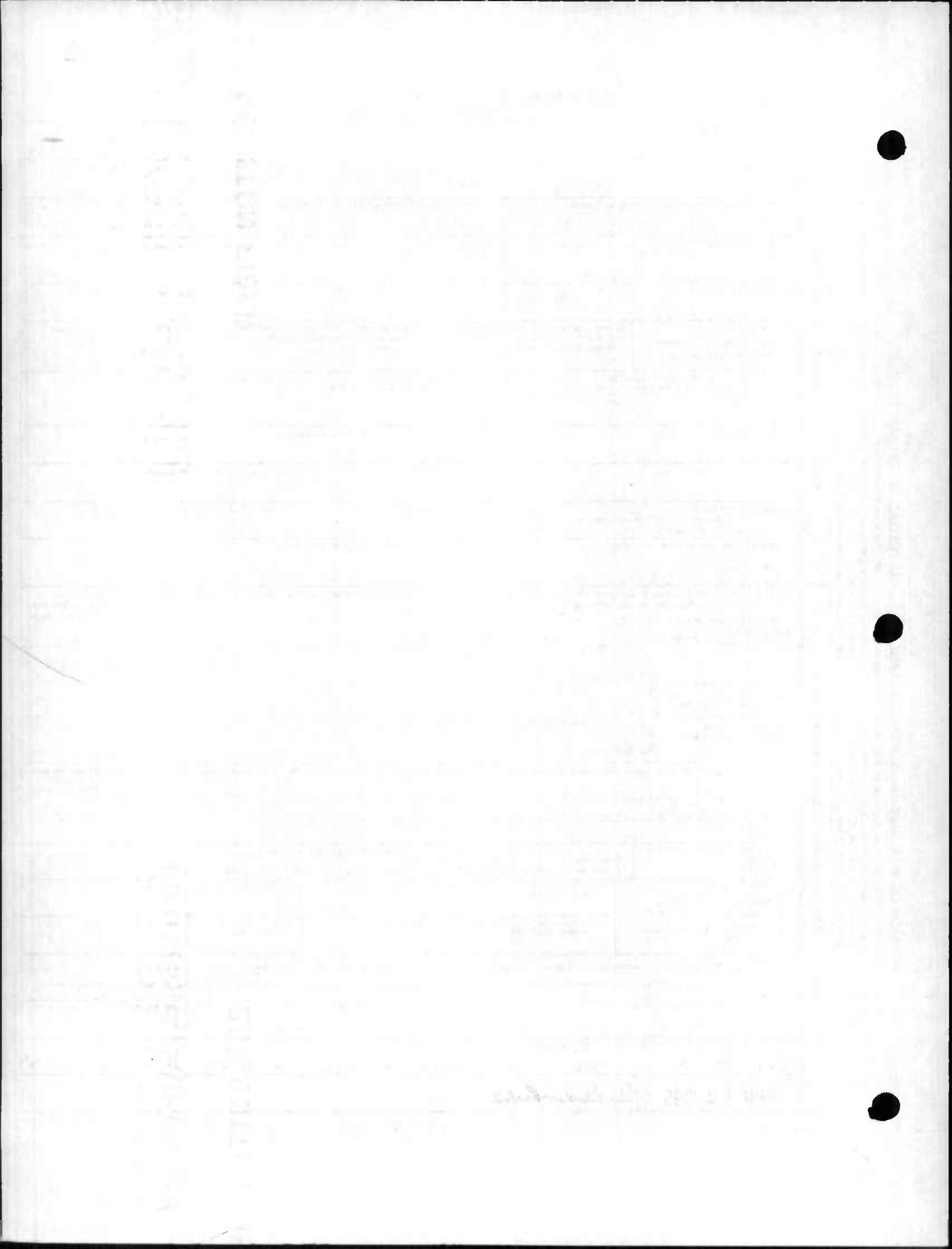
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11353

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Killian Hopkins</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>6th</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>10:10 AM</i>	
4. SOCIAL SECURITY NUMBER <i>874-56-6256</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>90</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7/13/04</i>		8. BIRTHPLACE (State or Foreign Country) <i>WRENS, VA</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Brun D. Rurwold</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BELCOMP MD</i>				9c. COUNTY OF DEATH <i>HARFORD</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Belcamp MD</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1133 Belcamp Rd</i>				10f. ZIP CODE <i>21017</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>N/A</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>		
17. FATHER'S NAME (First, Middle, Last) <i>ABRAHAM Campbell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>KATIE UNKNOWN</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Sylvia RHYMER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9294 TERRAZ LN JONASBORO, GA. 30236</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MD Zion Cemetery</i>		20c. LOCATION — City or Town, State <i>410 LANSLOWNE, MD.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louise Cromastie</i>				22. NAME AND ADDRESS OF FACILITY <i>BETTS FUNERAL HOME</i> <i>1129 N. CAROLINE ST BALTO, MD 21213</i>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Breast CA w. R mets</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <i>3 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Linda Freilich</i>						29c. LICENSE NUMBER <i>D28339</i>		29d. DATE SIGNED (Month, Day, Year) <i>APR 7 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Linda Freilich 101 East Wheel Rd. Bel Air, MD 21014</i>									
31. DATE FILED (Month, Day, Year) <i>APR 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>J. L. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PRICILLIO ALPHONSO HAINES				2. DATE OF DEATH MONTH DAY YEAR MARCH 31, 1995		3. TIME OF DEATH 14:00 P M	
4. SOCIAL SECURITY NUMBER 216-82-7841		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 31, 1962	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 226 E. PATRICK ST.		10. CITY, TOWN OR LOCATION OF DEATH FREDERICK	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION FREDERICK	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 226 E. Patrick STREET		10f. ZIP CODE 21701	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1982-1984	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer				16b. KIND OF BUSINESS/INDUSTRY N/A		17. FATHER'S NAME (First, Middle, Last) Joseph Haines	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Jones				19a. INFORMANT'S NAME (Type/Print) Joseph Haines		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 1001 CHERRY HILL ROAD Baltimore, Maryland	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 4/15/95 Garrison Forest Vet. Cem.		20c. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE S. J. Harris				22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road Garrison-Harris F.H. Baltimore, Md 21212		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC NARCOTICISM DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND ON 3/31/95		28b. TIME OF INJURY 2:00 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 226 E. PATRICK ST. FREDERICK, MARYLAND			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER OCME				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) APRIL 01, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 1 3 1995		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2009-510

blh ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-732 2/5/96 t.t  
Item20c 4-13-95 FilmG722 W.H. Per F/H

95 11355

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>Bryan PATRICK Houston</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10 1995</b>		3. TIME OF DEATH <b>0040</b> M	
4. SOCIAL SECURITY NUMBER <b>218-50-6138</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>39</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 25, 1955</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Hopkins at Bayview Medical Cntr</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>N/A</b>	
9. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4326 East Lombard Street</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Inspector</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William J. Houston</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Genevieve E. Martin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Barbara K. Houston</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4326 East Lombard Street Baltimore, Maryland 21224</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Parkwood Cemetery</b>		DATE <b>04/13</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. COMBINED DRUG INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>				Approximate Interval Between Onset and Death	
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PITUITARY ADENOMA, FATTY LIVER</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY <b>FOUND ON APRIL 9, 1995</b>		28b. TIME OF INJURY <b>FOUND AT 1:50 PM</b>	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4326 E. LOMBARD ST. BALTIMORE, MD.</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>	
				29d. DATE SIGNED (Month, Day, Year) <b>April 10 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore Maryland 21201</b>					
31. DATE FILED <b>APR 13 1995</b>					

BALTIMORE, MARYLAND 21215-0020



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BETTY HANLIN</b> Betty Ruth Hanlin				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>11 30 A</b>	
4. SOCIAL SECURITY NUMBER <b>236-20-8220</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 20, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3712 Edgewater Place</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3712 Edgewater Place</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>Housewife</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Edgar Bell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Charlotte Helen O'Day</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Selma E. Taylor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7014 Riverdrive Road Edgemere, MD 21219</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 4/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. END-STAGE COPD</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 MONTH</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC BRONCHITIS</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>95010</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>4940 Eastern Ave, Baltimore, MD 21224</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11357

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE I. HILTE				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 9:05 A M	
4. SOCIAL SECURITY NUMBER 216-28-1412		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-5-02	
8. BIRTHPLACE (State or Foreign Country) MD				9. FACILITY NAME (If not institution, give street and number) Meridian Loch Raven			
10. CITY, TOWN OR LOCATION OF DEATH Parkville				11. COUNTY OF DEATH Baltimore			
12. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY Baltimore 10c. CITY, TOWN OR LOCATION Phoenix 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				13. STREET AND NUMBER 14530 Manor Rd.			
14. ZIP CODE 21131				15. CITIZEN OF WHAT COUNTRY? USA			
16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: white	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unk. College (1-4 or 5+) unk.		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		22. KIND OF BUSINESS/INDUSTRY Own Home			
23. FATHER'S NAME (First, Middle, Last) (unk.) Peacock				24. MOTHER'S NAME (First, Middle, Maiden Surname) unk.			
25. INFORMANT'S NAME (Type/Print) Frank Hilte				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14530 Manor Rd. Phoenix, MD 21131			
27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer 4-12-95		29. LOCATION — City or Town, State Baltimore, MD			
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis S. Kelly</i>				31. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave.			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PROBABLE ALZHEIMER'S DEMENTIA</u>							
34. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				35. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		36. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
37. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
39. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		40. 28a. DATE OF INJURY (Month, Day, Year)		41. 28b. TIME OF INJURY M		42. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
43. 28d. DESCRIBE HOW INJURY OCCURRED				44. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				46. 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
47. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank Q. Aquino Jr.</i>				48. 29c. LICENSE NUMBER D14697		49. 29d. DATE SIGNED (Month, Day, Year) 04-11-95	
50. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK Q. AQUINO JR., MD, 8713 HARFORD RD. 21234							
51. 31. DATE FILED (Month, Day, Year) APR 13 1995				52. 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Robert</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11358

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Estellia Hooten</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:26 AM</b>	
4. SOCIAL SECURITY NUMBER <b>313-10-6921</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 29, 1910</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>		8c. COUNTY OF DEATH <b>Harford</b>	
9a. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Harford</b>				10c. CITY, TOWN OR LOCATION <b>BelAir</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>213 Crocker Drive</b>				10f. ZIP CODE <b>21014</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homekeeping</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Washington Surguy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Tessie Grace Calentine</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Gary Hooten, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2318 Reckord Road Joppa, Maryland 21085</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BelAir Memorial Gardens April 12, 1995</b>		20c. LOCATION — City or Town, State <b>BelAir, Maryland</b>		20d. DATE <b>April 12, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>E. F. Lassahn</b>				22. NAME AND ADDRESS OF FACILITY <b>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hypoxaemia, Respiratory Acidosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Respiratory Failure, Emphysema.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Acute Inf. wall Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Congestive heart failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>24 Hours.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>B. D. PAREKH MD.</b>					
		29c. LICENSE NUMBER <b>D18424</b>		29d. DATE SIGNED (Month, Day, Year) <b>April-9-1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. D. PAREKH MD. 1908 HARFORD ROAD, FALLSTON MD 21047.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>J. H. Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11359

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTIE JONES</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>8</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>6:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>246-12-0660</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 31, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N. CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>115 E. MELROSE- MERIDIAN N.H.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>115 E. MELROSE AVENUE</b>	
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <b>3 Widowed</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>XX</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify: <b>XX</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8 TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ST. JOSEPH HOSPITAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HENRY WILLIAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY WILLIAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES JONES JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3819 KIMBLEY ROAD, BALTIMORE, MD 21218</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL CEM. 4-12</b>		20c. LOCATION — City or Town, State <b>LAUREL, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal Failure</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertension</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Atherosclerotic Cardiovascular Disease</b> <b>Diabetes Mellitus</b>			
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>D22645</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11360

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Delores Johnson</u>				2. DATE OF DEATH MONTH <u>4</u> DAY <u>10</u> YEAR <u>95</u>		3. TIME OF DEATH <u>3:50 A</u> M	
4. SOCIAL SECURITY NUMBER <u>216 16 0680</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 15, 1923</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>John Hopkins Bayview</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>n/a</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>	
10c. CITY, TOWN OR LOCATION <u>Essex</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>147 Riverside Road</u>	
10f. ZIP CODE <u>21221</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Lawrence Staton</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret Bradfield</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Deanna Schepleng</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>147 Riverside Road Baltimore, Maryland 21221</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Greenmount Crematory 4/11/95</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis Secondary source unknown</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Severe ASCVD/SP CAD, Aorto femoral by pass</u> DUE TO (OR AS A CONSEQUENCE OF): <u>CAROTID ENDARTERECTOMY</u> DUE TO (OR AS A CONSEQUENCE OF): <u>SLP Colectomy x2 Small bowel resection</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HTN IDDM</u> <u>Cholecystectomy, Barrett's esophagus</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D04283</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/10/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>William B. Greenough, 5505 Hopkins Road, Catonsville, MD 21224</u>							
31. DATE FILED (Month, Day, Year) <u>APR 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11361

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KEVIN JAMES JOYNER</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>2</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8:34 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-64-7784</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 29 1958</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Hagerstown Correctional Ins.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>md</b>				10b. COUNTY <b>NIA</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4630 Pall Mall Rd</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (14 or 15+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Isaac Joyner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Debra Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Debra Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4630 Pall Mall Rd Balto, md 21215</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro</b>		20c. LOCATION — City or Town, State <b>4/2/95 Balto, md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE? <b>Portia Ebron</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. West 4300 Wabash Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio-Respiratory arrest</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Liver Failure</b>							<b>2 Mo</b>
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Aids Wasting Syndrome</b>							<b>2 YRS</b>
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>HIV Positive</b>							<b>10 YRS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>MCI INFIRMARY</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard E. Matthews M.D. PHYSICIAN</b>				29c. LICENSE NUMBER <b>D-23549</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/2/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard E. Matthews. M.D. Hagerstown, Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jane [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REG. NO.

DHMH-16 Rev 1/89



95 11363

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dennie Martin Jarvis</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>7</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>9:41 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>223-12-2617</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 10, 1920</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Wytheville, VA.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>	
9c. COUNTY OF DEATH <i>Harford</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Harford</i>	
10c. CITY, TOWN OR LOCATION <i>Joppa</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>412 Philadelphia Road</i>	
10f. ZIP CODE <i>21085</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Bus Driver</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Bus Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Samuel Jarvis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Fannie Hale</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Katherine C. Jarvis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>412 Philadelphia Rd. Joppa, Md. 21085</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral Cem. April 10, 1995</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>				22. NAME AND ADDRESS OF FACILITY <i>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary heart failure</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Coronary heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Atrial fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Soft tissue trauma</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i></i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i></i>		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <i></i>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i></i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i></i>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Smith Attending Physician</i>				29c. LICENSE NUMBER <i>D23519</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 9, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27, Type, Print) <i>Robert L. Smith, M.D. Fallston General Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>APR 13 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11364

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DORA JAMES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7 1995</b>				3. TIME OF DEATH <b>12:45 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>579 58 8622</b>				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct., 1, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Egypt</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>			9c. COUNTY OF DEATH <b>Montgomery</b>				
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>				10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6121 Montrose Road</b>						10f. ZIP CODE <b>20852</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles Grunspan</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rachel Navick</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Sheila J. Stone</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14833 Fireside Drive, Silver Spring, MD 20905</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>King David Mem. Gdns. 4/9/95</b>				20c. LOCATION (City or Town, State) <b>Falls Church, Virginia</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <b>Ives-Pearson Funeral Homes Falls Church, VA 22046</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ATHERO SCLEROTIC HEART DISEASE</b>													
DUE TO (OR AS A CONSEQUENCE OF):													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE</b>													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER <b>D 36552</b>			29d. DATE SIGNED (Month, Day, Year) <b>APRIL 7 1995</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PANKAJ TALWAR 6121 MONTROSE ROAD. ROCKVILLE MD. 20852</b>													
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11365

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Beatrice Theresa Kummel</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>		3. TIME OF DEATH <b>540 p m</b>	
4. SOCIAL SECURITY NUMBER <b>219-28-5035</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 25, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>STELLA MARIS</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>PARKVILLE</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2704 Berwick Ave</b>	
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ADMINISTRATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SOCIAL SECURITY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Kummel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>THERESA KOENIG</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOSEPH J. HLADKY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3703 PHILADELPHIA RD. ABINGDON, Md. 21009</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLY REDEEMER</b>		20c. LOCATION — City or Town, State <b>4134 Balto. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Graves</i>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES</b> <b>8800 HARFORD Rd. Balto. Md. 21234</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER <b>15506</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>2300 HILSONY Valley Road 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>John W. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11366

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AMELIA L. KOLBERG</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:15 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>233-34-6144</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 9, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>PARKVILLE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>7805 CHESTNUT AVE.</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT HOME</b>		15b. KIND OF BUSINESS/INDUSTRY <b>HOUSEWIFE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN J. Munsie</b>				18. MOTHER'S NAME (First, Middle, Last) <b>Jessie B. Munsie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEOFFREY V. KOLBERG</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9820 OLD COURT ROAD BALTIMORE MARYLAND 21244</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY 4-5-95</b>		20c. LOCATION — City or Town, State <b>Parkville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. BRAINSTEM CEREBROVASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Approximate interval between Onset and Death <b>5 hours</b> <b>15 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CACHEXIA, MULTIPLE DENTAL ABSCESES</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Serena R. Nolan MD</b>				29c. LICENSE NUMBER <b>D25010</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Serena R. Nolan, M.D., 8035A Harford Rd., Baltimore, Md. 21234</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11367

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOLORES JOAN KRESS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:22 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-24-3827</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 8, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Joppa</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1601 Philadelphia Road</b>	
10f. ZIP CODE <b>21085</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Edward A. Zink</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hazel F. Weber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carl E. Kress (Husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1601 Philadelphia Road, Joppa, MD 21085</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Waugh Chapel U.M.C. Cem. 4/14</b>		20c. LOCATION — City or Town, State <b>Long Green, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Respiratory Arrest</b> <span style="float: right;">Approximate Interval Between Onset and Death <b>1/2 hr.</b></span>							
b. <b>Arrhythmia</b> <span style="float: right;"><b>1/2 hr.</b></span>							
c. <b>Severe Coronary Artery Disease</b> <span style="float: right;"><b>5 years</b></span>							
d. <b>Diabetes Mellitus, Hypertension</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER <b>D 30653</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2112 Belair Road, Fallston, Maryland 21047</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11368

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Phillips Kolb</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>		3. TIME OF DEATH <b>20:50 P.</b>	
4. SOCIAL SECURITY NUMBER <b>014 26 0582</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 5, 1897</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Sykesville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7200 Third Ave.</b>				10f. ZIP CODE <b>21784</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>+5</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering Professor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>College</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Kolb</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emmma Spiese</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth-Ellen Ross</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5723 Apt. A. Harpers Farm Rd. Columbia, Md. 21044</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery April 13, 1995</b>		20c. LOCATION — City or Town, State <b>Washington, D.C.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harry W. Haight</b>				22. NAME AND ADDRESS OF FACILITY <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Brainstem Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Coma</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b>Hypotension</b> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Left Bronchial Mass, Renal Insufficiency, Pleural Effusion left lung</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER <b>D37944</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11th 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alexander Bradley Newberry, 1425 Lhewy Rd. Suite #208 Eldersburg, MD, 21784</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11369

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Seok Joo LEE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1995</b>		3. TIME OF DEATH <b>12:12 P M</b>		
4. SOCIAL SECURITY NUMBER <b>27-11-2093</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 1917</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>REEDS</b>		9c. COUNTY OF DEATH <b>Baltimore</b>		
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>PERRY HALL</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>8635 SAXON CIRCLE</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>KOREA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>KOREAN</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto Mechanic</b>				
17. FATHER'S NAME (First, Middle, Last) <b>HAG KYONG LEE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SUNG JA LEE</b>				
19a. INFORMANT'S NAME (Type/Print) <b>WOO KYONG LEE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8635 SAXON CIRCLE PERRY HALL, MARYLAND 21236</b>				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY 1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE MARYLAND</b>		20d. DATE <b>4-5</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W. B. F. Evans</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Multiple organ failure</b> DUE TO (OR AS A CONSEQUENCE OF):						3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Disseminated intravascular coagulation</b> DUE TO (OR AS A CONSEQUENCE OF):						3 days
		c. <b>Massive gastrointestinal ulceration</b> DUE TO (OR AS A CONSEQUENCE OF):						3 days
		d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Anthony Campbell</b>				29c. LICENSE NUMBER <b>RD 1763</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/95</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Anthony Campbell 9000 Franklin Square Drive Baltimore, MD 21237</b>								
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Reed</b>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11370

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles W Lawrence</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 16, 1995</b>				3. TIME OF DEATH <b>4:05 P M</b>					
4. SOCIAL SECURITY NUMBER <b>212-40-7364</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 4, 1942</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>938 Woodlynn Road</b>						10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1962-1966</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Yard Foreman</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Automotive Transport</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Raymond C. Lawerence</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carmo F. Drayer</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Lois Ann Lawerence</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>938 Woodlynn Rd. Baltimore, Maryland 21221</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Holly Hill Mem. Gardens 4/15/95</b>				20c. LOCATION — City or Town, State <b>Baltimore</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Baltimore MD. 21221</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart of Coronary Intervention.</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Coronary Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-09383</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell MD 408 Harfer House - 111 Hampden Hill Rd Baltimore MD 21210</b>													
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


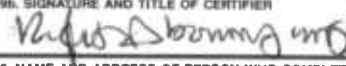

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11371

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDDIE LEMON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 30, 1995</b>		3. TIME OF DEATH HOURS MIN. SEC. <b>1:15 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>250-48-6111</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 17, 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3919 BOARMAN AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3819 BOARMAN AVENUE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th GRADE</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CARPENTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CARPENTRY SHOP</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM CARTER LEMON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PHYLISS GARRIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ETHELINA LEMON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3819 BOARMAN AVENUE, BALTIMORE, MARYLAND 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		DATE <b>4-5-95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME P.A. 1913 W. BALTIMORE ST. BALTIMORE, MD 21223</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PROBABLE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>CONGESTIVE HEART FAILURE</b>							
<b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>							
<b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MIN.		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>PHYSICIAN</b>				29c. LICENSE NUMBER <b>D12729</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RIFAT ABOUSY, M.D. 2300 GARRISON BLVD. BALTIMORE, MD 21216</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11372

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA E LEBER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:12</b>	
4. SOCIAL SECURITY NUMBER <b>716-18-0530</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 21, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Reisterstown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>222 Chartley Drive</b>				10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>domestic</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Johanson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna E. Johanson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rev. Clair L. Leber</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>222 Chartley Drive, Reisterstown, MD 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Memorial Gardens 4/10/95 Finksburg, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Eline</b>				22. NAME AND ADDRESS OF FACILITY <b>11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> <span style="float: right;">Approximate interval between Onset and Death <b>2 wks</b></span>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>PERITONITIS</b> <span style="float: right;"><b>2 wks</b></span>							
b. DUE TO (OR AS A CONSEQUENCE OF): <b>Ruptured viscous</b> <span style="float: right;"><b>2 weeks</b></span>							
c. DUE TO (OR AS A CONSEQUENCE OF): <b>SMALL BOWEL OBSTRUCTION</b> <span style="float: right;"><b>2 weeks</b></span>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. B. CONNAN MD</b>				29c. LICENSE NUMBER <b>019502</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. B. CONNAN MD NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD. 21133</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>John M. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11373

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Starr Sheldon Morrill</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 9, 1995</b>		3. TIME OF DEATH <b>10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-24-6189</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 25, 1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>513 Towson Ave</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LUTHERVILLE</b>		9c. COUNTY OF DEATH <b>BALTO</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>LUTHERVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>513 Towson Ave</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERVISOR</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Building Restoration</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank WHITNEY Morrill</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn Sheldon Walker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Julian Spencer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>204 Gittings Ave Balto. Md. 21212</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>		DATE <b>4/4/95</b>		20c. LOCATION — City or Town, State <b>BALTO. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert W. Groves</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS Chapel of Chimes 2325 York Rd. Timonium, Md. 21093</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Paul Celano</b>				29c. LICENSE NUMBER <b>D30129</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. Paul Celano GBMC Pavilion West Suite 205 Towson, Md 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. [Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11374

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUBY A. MYERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7 1995</b>		3. TIME OF DEATH <b>5:01 P M</b>	
4. SOCIAL SECURITY NUMBER <b>243 10 1957</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 9 1912</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Harford</b>		8c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BARFORD</b>		10c. CITY, TOWN OR LOCATION <b>Bel Air</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>909 CHERRY LANE</b>				10f. ZIP CODE <b>21014</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT Home</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSE WIFE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROY HARTMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY MOOREFIELD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LINDA M. JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1337 VANDERBILT ROAD BEL AIR, MARYLAND 21014</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDEN OF MEMORY 4-5-95</b>		20c. LOCATION — City or Town, State <b>WALKERTOWN, N.C.</b>		20d. LOCATION — City or Town, State <b>3000 NEWPORT DRIVE FOREST HILL, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21014</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ARTERIAL HYPERTENSION</b>					
		b. <b>HEART FAILURE</b>					
		c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>					
		d. <b>PNEUMONIA</b>					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of CARDIOVASCULAR DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D46412</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>319 S. UNION AVE HARFORD MD 21076</b>							
31. DATE FILED (Month, Day, Year) <b>4/7/95</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11375

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NELDA L. MUELLER</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-3728</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 20, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville 21237</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>511 Delaware Avenue</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lorenzo Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Molly Record</b>			
19a. INFORMANT'S NAME (Type/Print) <b>George S. Mueller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>511 Delaware Avenue Essex, Maryland 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Redeemer Cem. 4/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Brudzinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Cardiac arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Myocardial infarction</b>					Approximate Interval Between Onset and Death <b>13 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>13 days</b>
		c. <b></b> DUE TO (OR AS A CONSEQUENCE OF):					<b>years</b>
		d. <b></b> DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>P41680</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Adolph Wychulis 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11376

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jesus M. Vazquez Machin				2. DATE OF DEATH MONTH April DAY 11, YEAR 1995		3. TIME OF DEATH 5:25 A. M	
4. SOCIAL SECURITY NUMBER 580-72-9365		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1907	
9a. FACILITY NAME (If not institution, give street and number) 620 Longwood Court				9b. CITY, TOWN OR LOCATION OF DEATH Edgewood		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 620 Longwood Court				10f. ZIP CODE 21040		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Unknown College (1-4 or 5+) Unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security Guard		16b. KIND OF BUSINESS/INDUSTRY Security	
17. FATHER'S NAME (First, Middle, Last) Isabel Vazquez				18. MOTHER'S NAME (First, Middle, Maiden Surname) Angela Machin			
19a. INFORMANT'S NAME (Type/Print) Mrs. Carmen Aponte (daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Windy Branch Way, Edgewood, MD 21040			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. LOCATION — City or Town, State 4/13 Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE MYELOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) MARCH 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOAN P. EDWARDS, MD. 212 BELAIR ROAD AUSTIN, MARYLAND 21047							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11377

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Sylvia Bessie S. Moore</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10 28 P M</b>					
4. SOCIAL SECURITY NUMBER <b>215-28-9073</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/17/30</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland Hospital Baltimore</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3503 WOODLAND AVENUE APT. 3D</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Johnson</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Marcella Farmer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>448 E. 28th Street Baltimore, Maryland 21218</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS Memorial Park 4/12/95 ARBUTUS, Maryland</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Debra Harris</b>				22. NAME AND ADDRESS OF FACILITY <b>5240 REISTERSTOWN ROAD CHATMAN-HARRIS F.H. BALTIMORE, MD 21218</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTIC SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td><b>SPONTANEOUS BACTERIAL PERITONITIS</b></td> <td><b>48 HRS</b></td> </tr> <tr> <td><b>END STAGE LIVER DISEASE</b></td> <td><b>2 YRS</b></td> </tr> </table>							<b>SPONTANEOUS BACTERIAL PERITONITIS</b>	<b>48 HRS</b>	<b>END STAGE LIVER DISEASE</b>	<b>2 YRS</b>	Approximate interval Between Onset and Death
<b>SPONTANEOUS BACTERIAL PERITONITIS</b>	<b>48 HRS</b>										
<b>END STAGE LIVER DISEASE</b>	<b>2 YRS</b>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO					
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. [Signature]</b>				29c. LICENSE NUMBER <b>P08612</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/9/95</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>UMMS Baltimore, MD</b>											
31. DATE <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Michael Mellett  
218 14 9537

95 11378

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>12</b> YEAR <b>95</b>				3. TIME OF DEATH <b>7 30 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>218-14-9537</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>October 22, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good SAMARITAN Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>MD</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>MD</b>		10b. COUNTY <b>-----</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3918 Old York Road</b>						10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Navy, WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>White</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>-----</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Boilermaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>					
17. FATHER'S NAME (First, Middle, Last) <b>John Mellett</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Flynn</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mary Mechalske</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1454 B Warehime Rd. Westminster, Md 21158</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>-----</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery, April 15, 1995</b>				20c. LOCATION — City or Town, State <b>Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>						22. NAME AND ADDRESS OF FACILITY <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. END STAGE CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. -----</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. -----</b>  Approximate Interval Between Onset and Death <b>3-4 WEEKS</b> <b>YEARS</b>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE)</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>-----</b>									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. J. Jallapalli MD</b>						29c. LICENSE NUMBER <b>P 08238</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12, 95</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. J. Jallapalli GOOD SAMARITAN HOSPITAL BALTIMORE MD 21239</b>													
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. SIGNATURE OF REGISTRAR <b>[Signature]</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 1, File 722, 4/12/95, 1t

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEFFREY</b>				DR. JEFFREY S. MASSING				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 09 95</b>				3. TIME OF DEATH <b>6:33 P.M.</b>			
4. SOCIAL SECURITY NUMBER <b>215-48-7842</b>				5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F <b>1</b>		6. AGE (In yrs. last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 13, 1948</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>HOPKINS BAYVIEW MEDICAL CENTER</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>N/A</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>1</b>			
10e. STREET AND NUMBER <b>2901 BOSTON ST., APT. 212</b>								10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DENTIST</b>				16b. KIND OF BUSINESS/INDUSTRY <b>DENTISTRY</b>							
17. FATHER'S NAME (First, Middle, Last) <b>DAVID MASSING</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOAN FINK</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MR. DAVID MASSING</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>33 STONEHENGE CIRCLE, APT. 8 BALTIMORE, MD 21208</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW -4-12-1995 REISTERSTOWN, MD</b>				20c. LOCATION — City or Town, State <b>REISTERSTOWN, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>								22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Hypertensive Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b>												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. Kung</i>								29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>APRIL 10, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KUNG 111 PENN STREET BALTIMORE, MARYLAND 21201</b>															
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11380

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Rosita Moran</b>				2. DATE OF DEATH MONTH: <b>April</b> DAY: <b>07</b> YEAR: <b>1995</b>				3. TIME OF DEATH <b>4:25 P</b>	
4. SOCIAL SECURITY NUMBER <b>213-60-1157</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 29, 1908</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Villa Assumpta, 6401 N. Charles</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6401 N. Charles St.</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Francis M. Moran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella Lehman</b>					
19a. INFORMANT'S NAME (Type/Print) <b>S. Bernice Feilinger, SSND</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6401 N. Charles St., Baltimore, Md. 21212</b>					
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Villa Maria Cemetery</b>				DATE		20c. LOCATION — City or Town, State <b>Glen Arm, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert M. Kraft</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Rd. 21212</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Age - ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>5</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Boas</b>				29c. LICENSE NUMBER <b>D15871 MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Lawrence Boas, M.D. 54 Scott Adam Road, Cockeysville, Md. 21030</b>									
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Anderson Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11381

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>James Merriken</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 10 95</i>		3. TIME OF DEATH <i>11:55 P.M.</i>			
4. SOCIAL SECURITY NUMBER <i>411-16-9387</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>84</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>MAR. 15, 1911</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Charlestown Care Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>		9c. COUNTY OF DEATH <i>Baltimore County</i>			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>5712 Kenmore Road</i>				10f. ZIP CODE <i>21210</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Lumberman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Cooperage</i>					
17. FATHER'S NAME (First, Middle, Last) <i>William Merriken</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Julia Hearn</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Anne M. Goldsmith</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10 Bay Tree Lane, Mill Valley, California 94941</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley</i>		DATE <i>APR. 21</i>		20c. LOCATION — City or Town, State <i>Lutherville, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Z. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Ischemic Cardiomyopathy</i> c. d. Approximate Interval Between Onset and Death <i>2 days</i> <i>10 years</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Applebaum MD</i>		29c. LICENSE NUMBER <i>D34053</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/11/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gary Applebaum MD 711 Maiden Lane 21228</i>									
31. DATE FILED (Month, Day, Year) <i>APR 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>John D. [Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11382

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Edward NEAL Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10 1995</b>		3. TIME OF DEATH <b>10:20 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218 28 4963</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 17 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>Baltimore</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Sq. Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1102 Foxwood Lane</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Petroleum Products</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles E. Neal, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Shara Lackey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rita Neal</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1102 Foxwood Lane Baltimore, MD 21221</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) <b>Sacred Heart of Jesus Cem. 4/13/95</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdziński Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Left lung adenocarcinoma with metastasis to spine/brain</b>							<b>5 Months</b>
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>David San Miguel M.D.</b>				29c. LICENSE NUMBER <b>X P08262</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David San Miguel M.D. 9000 Franklin Square Drive Baltimore, Maryland 21234</b>							
31. FILED (Month, Day, Year) <b>APR 13 1995</b>				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 100  
The first part of the report  
concerns the general situation  
of the country. It is a  
very interesting and  
important document.  
The second part of the report  
concerns the specific  
situation of the country.  
It is a very interesting  
and important document.  
The third part of the report  
concerns the specific  
situation of the country.  
It is a very interesting  
and important document.  
The fourth part of the report  
concerns the specific  
situation of the country.  
It is a very interesting  
and important document.

95 11383

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alvina E. Nolte				2. DATE OF DEATH MONTH April DAY 12, YEAR 1995				3. TIME OF DEATH 11:45 A.M.							
4. SOCIAL SECURITY NUMBER 216-66-6725		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 23, 1902		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) 1518 Pentridge Road						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1518 Pentridge Road						10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) 6				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				15b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Max Schudel						18. MOTHER'S NAME (First, Middle, Maiden Surname) Emilie Bailer									
19a. INFORMANT'S NAME (Type/Print) Milton House						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 Manor View Road - Glen Arm, Md. 21057									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 4/15/95				20c. LOCATION — City or Town, State Parkville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald C. Schepke</i>						22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic Breast Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Cool MD</i>						29c. LICENSE NUMBER D34650				29d. DATE SIGNED (Month, Day, Year) 4/13/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey Cool, M.D. 5601 Loch Raven Blvd. Baltimore, Maryland 21239															
31. DATE FILED (Month, Day, Year) APR 13 1995						32. REGISTRAR'S SIGNATURE <i>Julia Anderson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11384

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elgin Gulick Overbey				2. DATE OF DEATH MONTH DAY YEAR April 8, 1995		3. TIME OF DEATH 3:30 P. M	
4. SOCIAL SECURITY NUMBER 212-14-1597		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 5, 1916	
9a. FACILITY NAME (If not institution, give street and number) 9919 Pepper Hill Road				9b. CITY, TOWN OR LOCATION OF DEATH Perry Hall		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Perry Hall		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9919 Pepper Hill Road				10f. ZIP CODE 21128		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Detective		16b. KIND OF BUSINESS/INDUSTRY Police Department			
17. FATHER'S NAME (First, Middle, Last) Walter R. Overbey				16. MOTHER'S NAME (First, Middle, Maiden Surname) Helen M. Crutchley			
19a. INFORMANT'S NAME (Type/Print) Marian C. Overbey (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9919 Pepper Hill Road, Perry Hall, MD 21128			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 4/12		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>VENTRICULAR ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER P20390		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Charles F. Hoesch, 9712 Belair Rd., Suite 203, Baltimore, MD 21236							
31. DATE FILED (Month, Day, Year) APR 13 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11385

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rollins Hall ROGERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 09, 1995</b>		3. TIME OF DEATH HOUR MIN <b>11:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212 07 4278</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 23, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Balto., Maryland</b>				9. COUNTY OF DEATH <b>Baltimore County</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville 21237</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>17 Elm Drive</b>			
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War 2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>12</b> College (1-4 or 5+) <b>Assembleman</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Aero-Space</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Aero-Space</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Rogers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nita Hall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nita R. Kraus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3538 Fitzhigh Lane Silver Spring, Maryland 20906</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens 4/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore County, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Brudzinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21220</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Acute MI</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Had DM - Type II, Prostatic adenoma.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MIN <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17148</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-10-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donna A. Rogers, JR 1010 B W. 1st St. Baltimore, MD 21220</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LARRY Donnell RHONE				2. DATE OF DEATH MONTH DAY YEAR APRIL 11 1995		3. TIME OF DEATH 7:30 P M	
4. SOCIAL SECURITY NUMBER 217-90-2643		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 20 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 6, 1974	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
11. COUNTY OF DEATH N/A				12. RESIDENCE OF DECEDENT 10a. STATE: Maryland 10b. COUNTY: N/A 10c. CITY, TOWN OR LOCATION: Baltimore		13. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. STREET AND NUMBER 322 E. 20 1/2 Street				15. ZIP CODE 21218		16. CITIZEN OF WHAT COUNTRY? USA	
17. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: Black	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11th grade College (1-4 or 5+)		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Kitchen Worker		23. KIND OF BUSINESS/INDUSTRY St. Josephs Hospital			
24. FATHER'S NAME (First, Middle, Last) Larry Blackwell				25. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn L. Rhone			
26. INFORMANT'S NAME (Type/Print) Carolyn Blackwell				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 E. 20 1/2 Street Baltimore, Maryland 21218			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 4/11/95		30. LOCATION — City or Town, State Randallstown, Maryland			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE DeWay Harris				32. NAME AND ADDRESS OF FACILITY CHATMAN-HARRIS F.H. Baltimore, Md 21218			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		36. DATE OF INJURY (Month, Day, Year) 4 11 95		37. TIME OF INJURY 1255 PM		38. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		40. DESCRIBE HOW INJURY OCCURRED GUNSHOT SHOT					
41. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1900 BLK BARCLAY ST BALTIMORE MD		42. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
43. SIGNATURE AND TITLE OF CERTIFIER Marilyn M. Thelwell				44. LICENSE NUMBER O.C.M.E		45. DATE SIGNED (Month, Day, Year) APRIL 12, 1995	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIA A. KOREN MD. 111 N. PENN ST. BALTIMORE, MARYLAND 21201							
47. DATE FILED (Month, Day, Year) APR 13 1995				48. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH &amp; Speed RANDOLPH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 6, 1995</b>		3. TIME OF DEATH <b>9:18 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>220-09-281</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 9, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Sparks</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>837 E. Quaker Bottom Road</b>			
10f. ZIP CODE <b>21152</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bus Attendant</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Baltimore County Department of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph T. Speed</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha A. Whye</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Scott</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>831 E. Quaker Bottom Road Sparks Maryland 21152</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem. 4/7/95</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James Harris</b>				22. NAME AND ADDRESS OF FACILITY <b>CHARTMAN-HARRIS F.H. Baltimore, Md 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>COED</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George Bedon MD</b>				29c. LICENSE NUMBER <b>D12732</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George Bedon GREATER BALTIMORE MEDICAL CENTER 6701 n Charles Street Towson, md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11388

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT Walter REIMER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:00 p m</b>			
4. SOCIAL SECURITY NUMBER <b>273-10-3156</b> <b>309-01-6784</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 22, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>		
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Cockeysville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10317 Malcolm Circle, apt D</b>				10f. ZIP CODE <b>21030</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chief Computer Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Walter Charles Reimer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Grabowsky Carhowsky</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Robert E. Reimer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10322 Gelding Dr., apt A, Cockeysville, MD 21030</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		DATE <b>13</b> <b>April</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bryan W. Clary</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon Funeral Home</b> <b>10 W. Padonia Road, Timonium, MD 21093</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Small bowel obstruction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. METASTATIC ADENOID CYSTIC CARCINOMA ABDOMEN</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ADENOID CYSTIC CARCINOMA PALATE</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>12 days</b> <b>3 yrs</b> <b>12 yrs</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dehydration</b> <b>malnutrition</b>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John R Saunders MD</b>				29c. LICENSE NUMBER <b>D28133</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-11-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN R SAUNDERS 6569 N. CHARLES ST #200 BALTIMORE MD 21204</b>									
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Saunders-Randall</b>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11389

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas Leo Sauerwald</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>7:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-23-6284</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>June 28, 1908</b>				8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Faulston General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Faulston</b>				9c. COUNTY OF DEATH <b>HARFORD</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>BALDWIN</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2612 GREEN ROAD</b>				10f. ZIP CODE <b>21013</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>SUBGRADUATE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUBGRADUATE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>PROCTER + GAMBLE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS FRANCIS SAUERWALD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE WOLF</b>					
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY H. CAULAHAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2612 GREEN ROAD BALDWIN, MARYLAND 21013</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND MEMORIAL PARK 4-10</b>				20c. LOCATION — City or Town, State <b>PARKVILLE MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL - BELAIR, P.A. 21020 3 NEWPORT DRIVE FOREST HILL, MARYLAND</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Respiratory Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiac Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Severe peripheral Vascular Disease</b>								Approximate Interval Between Onset and Death <b>5 mins</b> <b>72 hrs</b> <b>72 hrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe peripheral Vascular Disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter J. Golube M.D.</b>				29c. LICENSE NUMBER <b>D25349</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>319 S UNION AVE HANNE DE SHANE MD 21078</b>									
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11390

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET ELLEN SCOTT				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 9 :45 a.m.	
4. SOCIAL SECURITY NUMBER 218-18-6607		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 3, 1907	
8a. FACILITY NAME (If not institution, give street and number) 1100 PENNSYLVANIA AVENUE APT. 703				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8c. COUNTY OF DEATH n/a	
9. RESIDENCE OF DECEDENT				10a. STATE MARYLAND		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1100 PENNSYLVANIA AVENUE APT. 703				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 10 TH -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BAR MAID		16b. KIND OF BUSINESS/INDUSTRY ARCH SOCIAL CLUB			
17. FATHER'S NAME (First, Middle, Last) ERNEST SCOTT				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN			
19a. INFORMANT'S NAME (Type/Print) GLADYS COOPER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 MICKLE BLVD, APT. 1205 CAMDEN, NJ			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION C E M.		DATE 4-15		20c. LOCATION — City or Town, State LANSDOWNE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Arrhythmia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Common Artery disease b. DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary disease c. DUE TO (OR AS A CONSEQUENCE OF): Anemia d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hr Pulmonary Embolism SP Small bowel Obstructive order DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D31464		29d. DATE SIGNED (Month, Day, Year) 4/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHOARIS A. HASTHMI, 821 N. Entaw St Suite 308							
31. DATE FILED (Month, Day, Year) APR 13 1995		REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1974-510  
B.K.S

95 11391

ITEMS: 23 PART II, 27 PER MEO 6722 4/21/95 reb

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GARY SUITE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>7</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>1600 P M</b>					
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 1, 1947</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>531 NORTH MOUNT STREET 2ND FL.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH <b>N/A</b>				
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>531 N. Mount Street</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>							
17. FATHER'S NAME (First, Middle, Last) <b>ROGER SUITE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE PERCEY</b>							
19a. INFORMANT'S NAME (Type/Print) <b>SANDRA CORPORAL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2553 W. Lafayette Ave./Baltimore, MD 21216</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland National Park 4-13</b>		20c. LOCATION — City or Town, State <b>Laurel, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME EAST 1101 E. North Ave./Baltimore, MD 21202</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC ALCOHOLISM</b> <b>CHRONIC DRUG ABUSE</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 8, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET, BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11392

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert J. Shaw</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>12</b> , 1995 YEAR		3. TIME OF DEATH <b>7:23 A</b> M	
4. SOCIAL SECURITY NUMBER <b>313 10 3167</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 7, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1371 Sugarwood Circle</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Essex</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1371 Sugarwood Circle</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Telephone Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Winford Shaw</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Alice Byrd</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rebecca McCray</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1371 Sugarwood Circle Essex, Maryland 21221</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery 4/14</b>		20c. LOCATION — City or Town, State <b>Garrison Forest, Maryland</b>		20d. DATE <b>4/14</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kellie B Smaldone</i>				29c. LICENSE NUMBER <b>#40582</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-12-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kellie B Smaldone 2021 Elmwood Rd Ste 114 Bel Air MD 21015</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11393

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Phyllis Jeanne Schneider				2. DATE OF DEATH MONTH DAY YEAR April 11, 1995		3. TIME OF DEATH 12:15 p.m.	
4. SOCIAL SECURITY NUMBER 218-28-3706		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1931	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 2 Springknoll Drive		10. CITY, TOWN OR LOCATION OF DEATH Pasadena	
11. RESIDENCE OF DECEDENT 10a. STATE: Maryland 10b. COUNTY: Anne Arundel				12. CITY, TOWN OR LOCATION Pasadena		13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
14. STREET AND NUMBER 2 Springknoll Drive				15. ZIP CODE 21122		16. CITIZEN OF WHAT COUNTRY? USA	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: White	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		23. KIND OF BUSINESS/INDUSTRY Hospital E.R.			
24. FATHER'S NAME (First, Middle, Last) "Unknown"				25. MOTHER'S NAME (First, Middle, Maiden Surname) Augusta "Unknown"			
26. INFORMANT'S NAME (Type/Print) Roland Gilbert Schneider				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Springknoll Drive Pasadena, MD 21122			
28. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 04/12/95		30. LOCATION — City or Town, State Baltimore, MD			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Dawn F. McDonald				32. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Metastatic Small Cell Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): with lymph node, Liver, Adrenal Gland Metastases					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Russell P. DeLuca				29c. LICENSE NUMBER 031551		29d. DATE SIGNED (Month, Day, Year) April 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Russell DeLuca, M.D., 1600 Grain Hgwy, Suite 410, Glen Burnie, MD 21061							
31. DATE FILED (Month, Day, Year) APR 13 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA MARY AKA Elmira Mary Schafer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7, 1995</b>		3. TIME OF DEATH <b>4:37P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-05-1199</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 6, 1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>188 Jumpers Circle</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chief Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Telephone Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard L. Collins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva S. Wrightson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eva S. Winter (daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9224 Ramblebrook Road, Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem'l Gardens 4/11</b>		20c. LOCATION — City or Town, State <b>Timonium, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Acute Myocardial Infarction</b>					Approximate interval Between Onset and Death <b>?</b>
		b. <b>Coronary Artery Disease - presumed</b>					<b>?</b>
		c. <b>presumed</b>					<b>-</b>
		d. <b>presumed</b>					<b>-</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>4/7/95</b>		28b. TIME OF INJURY <b>11:00 AM</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D25169</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James HORN, M.D.; 10755 Falls Rd; Lutherville Md 21093</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Willie L. Sixel</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>2</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:15 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-24-0873</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-27-18</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>INNS OF EVERGREEN NW</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>510 Pulaski Street</b>			
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>Unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Lunch Room</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ellen Lewis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3600 W. Franklin Street Apt. 90 Baltimore, Md 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 4/13/95 Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gray Harris</b>				22. NAME AND ADDRESS OF FACILITY <b>CHATMAN-HARRIS F.H. Baltimore, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arrhythmia</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Atrial fib</b>						Approximate Interval Between Onset and Death <b>4/9/95</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b> <b>Aneurysm</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D27569</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Allen Battelman 1777 Rusters town Rd #365</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

APR 1 1902

95 11396

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SIMON</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> , 1995 YEAR				3. TIME OF DEATH <b>9 am</b> M	
4. SOCIAL SECURITY NUMBER <b>216-24-3980</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 25, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6303 PIMLICO ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6303 PIMLICO ROAD</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGEMENT</b>			16b. KIND OF BUSINESS/INDUSTRY <b>REAL ESTATE</b>		
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT SCHER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE KAGAN</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MRS. FREDA SCHER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6303 PIMLICO ROAD BALTIMORE, MD 21209</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HAR SINAI</b>		OATE <b>4-12-1995</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellenae Lewman</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b> Approximate interval Between Onset and Death <b>1 year</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arnold I. Boners MD</i>		29c. LICENSE NUMBER <b>016941</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>21 Cross roads Dr Owings Mills, Md 21117</b>									
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. MEDICAL EXAMINER'S SIGNATURE <i>John William Kordell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DWG

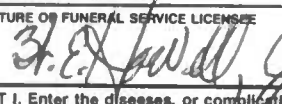
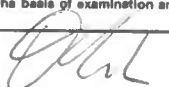

95 11397

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>LEON</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>04</b> YEAR <b>95</b>				3. TIME OF DEATH <b>7:54A</b>			
4. SOCIAL SECURITY NUMBER <b>219-26-5732</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 20 41</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY MARYLAND HOSP.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>NA</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>245 N. Spring St.</b>				10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>Unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Stevenson</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Romaine Coston</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Romaine Bailey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Terrence Pl. Belleville, NJ 20710</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt Zion Cem. 4/8/95</b>				20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Unity Funeral Home</b> <b>108 W. North Ave. Balto, MD 21201</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>MULTIPLE GUNSHOT WOUNDS WITH COMPLICATIONS</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  <b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>										Approximate interval between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> X/R Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>4-4-95</b>		28b. TIME OF INJURY <b>7:54 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED <b>VICTIM OF GUNSHOT WOUND</b>	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOUSE</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>101 E. EAGER STREET BALTIMORE, MD.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 05/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 							

DHMH-16 Rev 1/89

**BALTIMORE, MARYLAND 21215-0020**

**BOX 68760**

## DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





95 11398

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RYLE E. SPRINGMAN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215 20 7680</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/15/27</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>DVA MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FORT HOWARD</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1332 Evering Ave.</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1946 - 1947</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Work</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Board of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George W. Springman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hedwig T. Zurin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothea M. Springman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1332 Evering Ave. Baltimore, Md. 21237</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens 4-12-95 Cockeysville, Md.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. LUNG CANCER WITH BRAIN METASTASIS</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MFOCAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D15698</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MARCOS GALICIA, MD--9600 NORTH POINT/ROAD--FORT HOWARD, MARYLAND 21052</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11399

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACQUELINE MAUD SACCHINELLI</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>9:00 A.</b>	
4. SOCIAL SECURITY NUMBER <b>312-22-1997</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-19-1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>INDIANA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7974 OAKWOOD ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>	
10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7974 OAKWOOD ROAD</b>	
10f. ZIP CODE <b>21061</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL BUS DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ANNE ARUNDEL SCHOOLS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HERBERT STAMM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>WILLA MAE THAXTON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MICHELE A. ELLIOTT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7974 OAKWOOD ROAD, GLEN BURNIE, MD. 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		20c. LOCATION — City or Town, State <b>BROOKLYN PARK, MD.</b>		20d. DATE <b>4/13/1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death <b>Years</b> <b>Years</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D32449</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Clifford L. Amend MD 780 Ritchie Hwy Severna Park MD 21146</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11400

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Doris LUCILLE SCHUMANN				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 6:35 a <sup>m</sup>	
4. SOCIAL SECURITY NUMBER 216-01-9880		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 12, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH BALTIMORE COUNTY		9b. COUNTY OF DEATH BALTIMORE	
9c. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore County				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5507 East Avenue	
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Housekeeping	
17. FATHER'S NAME (First, Middle, Last) Frank Frederick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Barley			
19a. INFORMANT'S NAME (Type/Print) Mrs. Linda C. Lurz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 East Avenue Baltimore, Md. 21206			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY APRIL 13, 1995		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home, Inc.</i>				22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):							
2 years							
b. Atherosclerotic Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):							
20 years							
c. Hypertension DUE TO (OR AS A CONSEQUENCE OF):							
30 years							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Randolph DeCarlo</i>				29c. LICENSE NUMBER D44918		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Randolph DeCarlo, M.D. 9000 Franklin Square Drive, Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11401

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Evelyn F Smith</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>10</b> YEAR <b>95</b>		3. TIME OF DEATH <b>11:15P M</b>	
4. SOCIAL SECURITY NUMBER <b>254-26-1810</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 29, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fairhaven</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Sykesville</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Carroll County</b>				10c. CITY, TOWN OR LOCATION <b>Sykesville</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7200 Third Avenue</b>			
10f. ZIP CODE <b>21784</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Clyde Marion Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Janie Fanning</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Jane Jennings</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2600 Plyers Mill Road Silver Sping, MD</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Serv. 4/11/95</b>		DATE <b>Hampstead, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian D. Haight</i>				22. NAME AND ADDRESS OF FACILITY <b>HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>sudden death, likely arrhythmia or MI</b>					Approximate Interval Between Onset and Death <b>immed</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>congestive heart failure</b>					<b>one yr</b>
		c. <b>pulmonary hypertension and</b>					<b>years</b>
		d. <b>chronic atrial fibrillation</b>					<b>"</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rich P. Allan MD</i>				29c. LICENSE NUMBER <b>D34406</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richmond P. Allan, 1645 Liberty Rd. Eldersburg, MD 21784</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>Jalia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jeanette Elizabeth Schwarzmann</b>			2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1995</b>		3. TIME OF DEATH <b>12:45 AM</b>
4. SOCIAL SECURITY NUMBER <b>215-03-8211</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Apr 10 1910</b>	8. BIRTHPLACE (State or Foreign Country) <b>POLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>	10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>TOWSON</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>2300 Dulaney Valley Rd.</b>			10f. ZIP CODE <b>21204</b>	10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Gac</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Sikora</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Suzanne J. Gallagher</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4006 Milldale Ct., Phoenix, MD 21131</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens 13 APR</b>		20c. LOCATION — City or Town, State <b>Timonium, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bryan W. Clary</b>			22. NAME AND ADDRESS OF FACILITY <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory failure</b> <b>Chronic obstructive lung disease</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerosis with myocardial infarction</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>					Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBER <b>1713904</b>	29d. DATE SIGNED (Month, Day, Year) <b>4-10-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>E. M. [illegible] 2300 Dulaney Valley Road 21204</b>					
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE <b>John [illegible]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jeanette Tilkin</i>				2. DATE OF DEATH MONTH <i>Apr</i> DAY <i>9</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>8:30 AM</i>	
4. SOCIAL SECURITY NUMBER <i>215-326-072</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>93</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Aug 16 1901</i>	
8. FACILITY NAME (If not Institution, give street and number) <i>Levindeh</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6940 BROOKMILL RD., APT. #1-A</i>				10f. ZIP CODE <i>21215</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th.</i> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>AT HOME</i>			
17. FATHER'S NAME (First, Middle, Last) <i>ZALMAN WEINRAUB</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSE RAFFEL</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MR. STANLEY TILKIN</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1000 VALLEY FORGE CIRCLE, APT. 704 KING OF PRUSSIA PA. 19406</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>B'NAT ISRAEL - SOUTHERN AVE. 04/11/95 BALTIMORE, MD.</i>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215</i>					
22. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia Deep vein Thrombosis</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Myaen - Physician</i>				29c. LICENSE NUMBER <i>D 44817</i>		29d. DATE SIGNED (Month, Day, Year) <i>Apr 11 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUNIL P. RAJANI, 2434 W Belvedere ave, Baltimore MD</i>							
31. DATE FILED (Month, Day, Year) <i>APR 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1976-510  
B.K.S

95 11404

ITEMS: 23 PART I, 27 PER MEO G-7224/21/95 reb

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM UPP JR.				2. DATE OF DEATH MONTH DAY YEAR APRIL 07 1995		3. TIME OF DEATH 1838 P.M.	
4. SOCIAL SECURITY NUMBER 218 52 2754		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 45 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 2, 1950	8. BIRTHPLACE (State or Foreign Country) Balto., Maryland		
9a. FACILITY NAME (If not institution, give street and number) 3812 BANKS STREET			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A		
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3812 Bank Street			10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Clothing Co.			
17. FATHER'S NAME (First, Middle, Last) William H. Upp, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dolores Stevens			
19a. INFORMANT'S NAME (Type/Print) Beverly Tull				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Fitzhugh Road Joppa, Maryland 21085			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cem. 4/11/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 13 1995		32. REGISTRAR'S SIGNATURE 					

BALTIMORE, MARYLAND 21215-0020  
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11405

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lena B. Van Fossen				2. DATE OF DEATH MONTH DAY YEAR April 5, 1995		3. TIME OF DEATH 11:25P M	
4. SOCIAL SECURITY NUMBER 214-03-0901		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 30, 1895	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridian Perring Parkway		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY -----	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1905 Griffis Avenue	
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) Unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hatter		16b. KIND OF BUSINESS/INDUSTRY Hat Manufacturer	
17. FATHER'S NAME (First, Middle, Last) August Bruns				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise (Surname Unknown)			
19a. INFORMANT'S NAME (Type/Print) John C. Bruns (nephew)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Yarmouth Lane, Bel Air, MD 21014			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 4/7		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 9705 Belair Road, Baltimore, Md. 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death yes yes							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Relay death due to pneumonia. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DOF358		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. P. A. + K. PATRIZIO M.D. 703 S. Clinton St., Balt. MD 21224							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.








95 11406

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AGNES Margaret Waicker</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 11 1995</b>		3. TIME OF DEATH <b>1 30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-05-4570</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 3, 1901</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>115 Deepdale DR.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Timonium</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>115 Deepdale Dr.</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward Pierce Vincente</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>AGNES Elma Ammel</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris Zimmerman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Deepdale DR. Timonium, Md 21093</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDENS of FAITH</b>		DATE <b>4/11/95</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL of CHIMES 2325 York Rd Timonium, Md 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC CANCER OF RIB</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							Approximate Interval Between Onset and Death <b>6 months</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D25686</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-12-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. FERAHIM I. PAKCHI 7600 OSLER DR. Towson, Md. 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


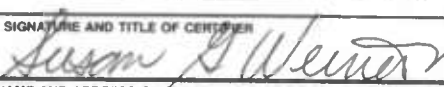

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11407

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA WALSH</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>12</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>7:30 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>142-20-5326</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 11, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8 Eyre Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8 Eyre Court</b>	
10f. ZIP CODE <b>21236</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6th grade</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Presser</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Garment Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Fowler Conklin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Conklin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eileen VanPoppel (Sister)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 Eyre Court, Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fairview Cemetery 4/15</b>			
20c. LOCATION — City or Town, State <b>Sussex, N.J.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Anemia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Probable Colon Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Leukocytosis</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <b>2 mos</b> <b>2 mos</b> <b>2 mos</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER <b>D34941</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 12, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SUSAN G. Weiner MD 5601 Loch Raven Blvd Baltimore, Md 21239</b>				31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>			
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11408

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John Gilbert Wagner, Sr.</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>9</i> , YEAR <i>1995</i>		3. TIME OF DEATH <i>11:30 P. M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-10-2422</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 5, 1917</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Nursing Center-Cromwell</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2 Knaves Court</i>				10f. ZIP CODE <i>21236</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Salesman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Lumber Company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Anthony Wagner</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Adeline Christine Pickering</i>			
19a. INFORMANT'S NAME (Type/Print) <i>John G. Wagner (son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>c/o Shell Oil Co., Rm. 2474, P.O. Box 2466, Houston, TX 77252</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Joseph's Cemetery</i>		DATE <i>4/12</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Sockacki</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Arteriosclerotic coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d. DUE TO (OR AS A CONSEQUENCE OF):</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion Kowalewski MD</i>				29c. LICENSE NUMBER <i>D21022</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-10-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARION KOWALEWSKI 8604 HARTFORD RD</i>							
31. DATE FILLED (Month, Day, Year) <i>APR 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Warren</b>				2. DATE OF DEATH MONTH <b>4</b> - DAY <b>11</b> - YEAR <b>95</b>		3. TIME OF DEATH <b>6:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>213-94-2154</b>		5. SEX <b>MALE</b>		6. AGE (In yrs. last birthday) <b>30</b> YRS.		7. DATE OF BIRTH <b>April 29, 1964</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>BALTO.</b>		10. COUNTY OF DEATH <b>N/A</b>	
11. FACILITY NAME (If not institution, give street and number) <b>1017 McAlister Ct</b>				12. RESIDENCE OF DECEDENT			
13. STATE <b>MD.</b>		14. COUNTY <b>N/A</b>		15. CITY, TOWN OR LOCATION <b>BALTO.</b>		16. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
17. STREET AND NUMBER <b>1017 McAlister Ct</b>				18. ZIP CODE <b>21202</b>		19. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
20. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (14 or 5+) <b>N/A</b>		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unemployed</b>		26. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
27. FATHER'S NAME (First, Middle, Last) <b>Henry Warren</b>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucille Blanch</b>			
29. INFORMANT'S NAME (Type/Print) <b>Lucille Warren</b>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1017 McAlister Ct. BALTO. MD 21202</b>			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. John's Cemetery 4/12/95</b>		33. LOCATION — City or Town, State <b>BALTO. MD</b>			
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betha Funeral Home</b>				35. NAME AND ADDRESS OF FACILITY <b>1129 N. Caroline St. BALTO. MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → { a. <b>Chronic infection</b> b. <b>Acquired Immuno deficiency Syndrome</b> c. } SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatitis B infection</b>							
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		27. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
28. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		29. DATE OF INJURY (Month, Day, Year)		30. TIME OF INJURY <b>M</b>		31. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				33. DESCRIBE HOW INJURY OCCURRED			
34. LOCATION (Street and Number or Rural Route Number, City or Town, State)				35. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>			
36. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
37. SIGNATURE AND TITLE OF CERTIFIER <b>Stacy Anderson MD</b>				38. LICENSE NUMBER		39. DATE SIGNED (Month, Day, Year)	
40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1000 E. Eager St. Baltimore MD 21202</b>							
41. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				42. REGISTRAR'S SIGNATURE <b>John A. Henderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

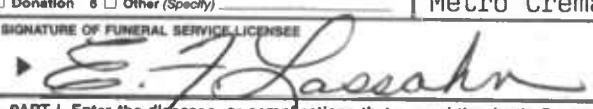
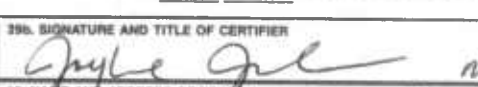
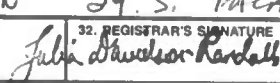




95 11410

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Oscina Wood</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9th</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:40 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>219-12-7049</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 6, 1905</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		8c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Fallston</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2700 Laurel Brook Road</b>				10f. ZIP CODE <b>21047</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th.</b> College (1-4 or 6+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George W. Martin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Inewick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Cornelia LaCoste</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2700 Laurel Brook Rd. Fallston, Md. 21047</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory April 10, 1995</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>							Approximate Interval Between Onset and Death <b>years</b> <b>1 wk</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Dementia</b> <b>Parkinson's</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>802438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joylene John 29 S. PACA UFP BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John F. WINTERLING				2. DATE OF DEATH MONTH DAY YEAR April 5, 1995		3. TIME OF DEATH 8:06 a.m.	
4. SOCIAL SECURITY NUMBER 220-20-9012		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/24/29	
8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD.							
9a. FACILITY NAME (If not institution, give street and number) Franklin Square ER				9b. CITY, TOWN OR LOCATION OF DEATH BALTO, MD 21237		9c. COUNTY OF DEATH Baltimore County	
10a. STATE MD		10b. COUNTY BALTO		10c. CITY, TOWN OR LOCATION BALTIMORE COUNTY		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5118 Terrace DR				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES JANUARY 24, 1952 - JANUARY 23, 1961		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CIVIL ENGINEER		16b. KIND OF BUSINESS/INDUSTRY CONSULTING ENGINEERS			
17. FATHER'S NAME (First, Middle, Last) JACQUE WINTERLING				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY DEASEL			
19a. INFORMANT'S NAME (Type/Print) MARGARET A. WINTERLING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5118 TERRACE DRIVE BALTIMORE, MARYLAND 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEMETERY APRIL 8, 1995		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home, Inc.				22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Hypertensive & Atherosclerotic Cardiovascular Disease					Approximate interval Between Onset and Death years
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joel Cherry, MD				29c. LICENSE NUMBER D04353		29d. DATE SIGNED (Month, Day, Year) 4/5/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joel Cherry, M.D., 6609 Reisterstown Road, Baltimore, MD 21215							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE John A. Harrison			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS H. BARNARD D.D.S.</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>046-18-0533</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 17, 1925</b> Ct.	
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1000 E. Joppa Rd.</b>				10f. ZIP CODE <b>21286</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW-II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dentistry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Francis Parker Barnard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida M. Haller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Selma Barnard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1000 E. Joppa Rd. Towson, Md. 21286</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 4/13/95</b>		20c. LOCATION — City or Town, State <b>Towson, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>HEPATORENAL SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ALCOHOLIC (CIRRHOTIC) LIVER DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE ELECTROLYTE DISTURBANCES</b> <b>CARDIOMYOPATHY</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D32637</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TIMOTHY HERLIHY 6212 YORK RD BAIT MD. 21212</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11413

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANK CRISSMAN BRODERICK</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:35 am</b>	
4. SOCIAL SECURITY NUMBER <b>370-28-7373</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/6/20</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Carney</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1806 Rushley Road</b>			
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs.</b> College (1-4 or 5+) <b>Credit Analyst</b>				16. KIND OF BUSINESS/INDUSTRY <b>Commercial Credit</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Morris Broderick</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Unavailable</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Crissman Broderick</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1806 Rushley Road Baltimore, MD 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gar. 4/17/95 Cockeysville, MD</b>		20c. LOCATION — City or Town, State		20d. DATE <b>4/17/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Christina R. Kopezyk</b>				22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>MYOCARDIAL INFARCTION</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. DUE TO (OR AS A CONSEQUENCE OF):					
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Pemy Chhim M.D.</b>				29c. LICENSE NUMBER <b>D26954</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-12-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PEMY CHHIM, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>		REGISTRAR'S SIGNATURE <b>Jalia [Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1944

1944

1944

1944

1944



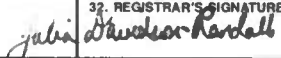
1944



95 11414

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Barley</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1510</b> M	
4. SOCIAL SECURITY NUMBER <b>214-18-1192</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 20, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1404 Oakland Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Reisterstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Reisterstown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1404 Oakland Road</b>				10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Millwright</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Morris Barley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Fannie Farmer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ida Barley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1404 Oakland Rd., Reisterstown, Md. 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens 04/17/95</b>		20c. LOCATION — City or Town, State <b>Finksburg, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel</b> <b>11605 Reisterstown Rd., Owings Mills, Md. 21117</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ISCHEMIC CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D37333</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 13, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. Ravi, MD, NHC, BALTO. MD 21133</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11415

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH COLEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> YEAR <b>95</b>				3. TIME OF DEATH <b>12-45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-01-3356</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10 15 1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2601 Roslyn Avenue</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>N/A</b> (Elementary/Secondary (0-12))		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		16. KIND OF BUSINESS/INDUSTRY <b>Hotel Industry</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Mincer Coley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jeweline Reed</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Joseph D. Coley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>620 Linnard Street Baltimore, Maryland</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION 4-15 Baltimore</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Irvin Carroll</i>				22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll 1712 W. North Ave.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. Right (parietal) Cerebro-vascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <b>Days</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. M. SHANAHAN</b>				29c. LICENSE NUMBER <b>D19668</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-10-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R.M. SHANAHAN, 2200 LIBERTY AVE, Baltimore, MD.</b>									
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11416

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lawrence G Campbell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 12 1995</b>		3. TIME OF DEATH <b>1550</b> M	
4. SOCIAL SECURITY NUMBER <b>189-30-9043</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 17, 1940</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5817 HERON DRIVE</b>	
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREAN</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>H/S GRAD</b> College (1-4 or 5+) <b>PAYROLL SUPERVISOR</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PAYROLL SUPERVISOR</b>				16b. KIND OF BUSINESS/INDUSTRY <b>ALLIED SIGNAL CORPORATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FREDERICK G. CAMPBELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE B. BAILEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOLORES A. CAMPBELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5817 HERON DRIVE - ARBUTUS, MD. 21227</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREENMOUNT CREMATORY 4/17 BALTIMORE</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Heuis E. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>multisystem organ failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>liver failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>renal failure</b>							
24. IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
25. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
26a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				30. DATE OF INJURY (Month, Day, Year) <b>APR 12 1995</b>			
31. TIME OF INJURY <b>M</b>				32. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
33. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				34. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
35. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
36. SIGNATURE AND TITLE OF CERTIFIER <i>John G. Anderson MD</i>				37. LICENSE NUMBER <b>1239370</b>			
38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ST Agnes Htl. Balt Md.</b>				39. DATE SIGNED (Month, Day, Year) <b>April 12, 1995</b>			
40. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				41. REGISTRAR'S SIGNATURE <i>John G. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

12+1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11417

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARLIN DAVIS</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:45 am</b>	
4. SOCIAL SECURITY NUMBER <b>204-03-2376</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 28, 1920</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Joppa</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>706 Falconer Rd.</b>				10f. ZIP CODE <b>21085</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW-II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machine Operator</b>		15b. KIND OF BUSINESS/INDUSTRY <b>American Can Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ellis Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Melba Rupp</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Elsie Davis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>706 Falconer Rd. Joppa, Md. 21085</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 4/15/95</b>		20c. LOCATION — City or Town, State <b>Middle River, Md.</b>		20d. DATE <b>4/15/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. SEPSIS</b>					
Approximate Interval Between Onset and Death		<b>DAYS</b> <b>DAYS</b> <b>DAYS</b> <b>DAYS</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard L. Linthicum MD</b>				29c. LICENSE NUMBER <b>D 31826</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-12-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RICHARD L. LINTHICUM, M.D., ST. JOSEPH MEDICAL CENTER, TOWSON, MD. 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1988-1989

1988-1989

1988-1989

1988-1989

1988-1989

1988-1989

RESPIRATORY FAILURE

ADULT RESPIRATORY DISTRESS SYNDROME

PNEUMONIA

ARDS

1988-1989

1988-1989



95 11418

ITEM: 3. PER MEDICAL FACILITY FILM G-726 8/30/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVA FLEMING</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-18-2284</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-3-1898</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>IRVINGTON KNOLLS CARE CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>22 S. ATHOL AVENUE</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNK</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNK</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SHEILA WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 S. ATHOL AVE. BALTO. MD. 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 04-13-95</b>		20c. LOCATION — City or Town, State <b>LANSDOWNE MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>4 yrs</b> <b>4 yr</b> <b>4 yr</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Amatun N. Hareem MD</b>				29c. LICENSE NUMBER <b>D 15503</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AMATUN N. HAREEM, 501 Dolphin St Balto, MD 21217</b>							
31. FILED (Month, Day, Year) <b>APR 14 1995</b>		REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET A Anna FRANCIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7, 1995</b>		3. TIME OF DEATH <b>5:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-10-8742</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/16/01</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7425 Beebee Drive</b>				10f. ZIP CODE <b>20855</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th GRADE</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM FISHPAUGH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY WAGNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DONALD L. FRANCIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7425 Beebee DRIVE ROCKVILLE, MD 20855</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM. GAR. 4/11/95</b>		20c. LOCATION — City or Town, State <b>COCKEYSVILLE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina D. Kopy...</i>				22. NAME AND ADDRESS OF FACILITY <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>CA COLON</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>GI BLEED w/ ANEMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>CVA/OLD STROKES</b> DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KENDALL FAULKNER, M.D. 2300 Dulaney Valley Road Lutherville, MD 21092</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Bernie L. Gaddy</b>				2. DATE OF DEATH MONTH <b>4</b> - DAY <b>1</b> - YEAR <b>95</b>		3. TIME OF DEATH <b>9:24/A</b> M	
4. SOCIAL SECURITY NUMBER <b>226-36-7894</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-27-28</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>		9a. FACILITY NAME (If not institution, give street and number) <b>316 N. Fulton Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>316 N. Fulton Avenue</b>		10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Gaddy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mae McCoy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Clinton D. Hudgins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1814 Rutland Ave. Balt. Maryland</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		DATE <b>4/5</b>		20c. LOCATION — City or Town, State <b>Baltimore</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll 1712 W. North Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Attending Physician</b>				29c. LICENSE NUMBER <b>030631</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/3/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Alan Reisinger MD 5411 Old Frederick Rd Balto MD 21228</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE 			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LINDA REGINA GORSUCH				2. DATE OF DEATH MONTH DAY YEAR APRIL 10 1995		3. TIME OF DEATH 3:40 A <sup>M</sup>	
4. SOCIAL SECURITY NUMBER 544-52-7719		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/23/48	
8. BIRTHPLACE (State or Foreign Country) WASHINGTON				9a. FACILITY NAME (If not institution, give street and number) 8324 EDGEDALE RD		9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Parkville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8324 Edgedale Road	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th GRADE n/a				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) UNAVAILABLE				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNAVAILABLE			
19a. INFORMANT'S NAME (Type/Print) LEWIS J. GORSUCH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8324 Edgedale Road Baltimore, MD 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 4/13/95		20c. LOCATION — City or Town, State Cockeysville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christina L. Kopych				22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>NORTRIPTYLINE INTOXICATION</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-9-95 FOUND		28b. TIME OF INJURY 11:50 P <sup>M</sup>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED DRUGS		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8324 EDGEDALE BALTIMORE, MD.			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. Kopych				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 10 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. Kopych 111 PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE John Andrew Radak			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PALOMA de Dios Wilson GARCIA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 11, 1995</b>		3. TIME OF DEATH <b>16:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-29-9920</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>4</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 11, 1990</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6924 Knighthood Lane</b>				10f. ZIP CODE <b>21045</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>Cuban</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Child</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Manuel Garcia</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wanda Wilson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Wanda Wilson Garcia (Mother)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6924 Knighthood Lane, Columbia, MD 21045</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>1st Baptist Church Cem. Apr. 15, 1995</b>		20c. LOCATION — City or Town, State <b>Columbia, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year) <b>4 8 95</b>		26b. TIME OF INJURY <b>1300 P M</b>		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>		26e. DESCRIBE HOW INJURY OCCURRED <b>PASSENGER IN CAR STRUCK BY</b>					
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>SHOWNEN RIVER PKWY ITA WIS CO MD</b>		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYANN A. KOREN MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11423

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HERBERT H HARDMAN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-03-2765</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 9, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>TOWSON</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7734 GREENVIEW TERRACE APT. 213</b>	
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College (14 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALESMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>	
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL HARDMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAYHEW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LEAH HARDMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7734 GREENVIEW TERRACE APT. 213 TOWSON, MD. 21204</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP. 4/13/95</b>		20c. LOCATION — City or Town, State <b>TOWSON, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> <b>JOHN E. DOLAN</b>				22. NAME AND ADDRESS OF FACILITY <b>RUCK TOWSON FUNERAL HOME INC 1050 YORK ROAD TOWSON, MD. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTRACEREBRAL HEMMORHAGE</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>18 HRS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katharine Armstrong MD</i> <b>MD</b>				29c. LICENSE NUMBER <b>D46142</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KATRINA ARMSTRONG 6565 N CHARLES ST BALTO MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John E. Dolan</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11424

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ernest Wilbur Humphreys Jr.</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:20 p m</b>	
4. SOCIAL SECURITY NUMBER <b>218-28-0267</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-5-1931</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3260 Maple Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Manchester</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Manchester</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3260 Maple Ave.</b>	
10f. ZIP CODE <b>21102</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean Conflict</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Policeman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ernest Wilbur Humphreys Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mariam Adele Meeks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eileen D. Humphreys</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3260 Maple Ave., Manchester, Md. 21102</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem. 04/17/95</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. E. Schmitt</i>	
22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pancreatic Adenocarcinoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Faggett MD</i>				29c. LICENSE NUMBER <b>D15546</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-13-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles Faggett MD 5601 Loch Raven Blvd., Balto. Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11425

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert A. Hill Jr.</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:00am</b> M	
4. SOCIAL SECURITY NUMBER <b>229-22-4298</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 12, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>983 Fall Circle Way</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Gambrills</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>983 Fall Circle Way Gambrills</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>983 Fall Circle Way</b>	
10f. ZIP CODE <b>21054</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrical Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Westinghouse</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert A. Hill Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Augusta Frazier</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Duvall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Gambrills, MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Blandford Cemetery 4/12</b>		20c. LOCATION — City or Town, State <b>Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Ochaney M.D.</i>				29c. LICENSE NUMBER <b>D-40521</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. OCHANAY 3350 WILKINS AVENUE SUITE 306 BALTIMORE, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11426

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bertha Holland</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:32 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220-30-0076</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 12, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Millersville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>701 Morris Tongue Drive</b>	
10f. ZIP CODE <b>21108</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (14 or 5+) <b>Homemaker</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Truman Harrison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rachel Williams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mano A. Ceaphus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1734 Swann St. N.W. Washington, DC 20009</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Md Nat'l Memorial Park 4/17</b>		20c. LOCATION — City or Town, State <b>Laurel, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas D. Hardesty</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>GLUTEAL PELVIC ABSCESS</b> b. <b>PNEUMONIA</b> c. <b>ORGANIC BRAIN SYNDROME</b> d. <b>3 weeks</b> e. <b>3 weeks</b> f. <b>3 weeks</b> g. <b>3 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dan H. Schreier, MD</b>				29c. LICENSE NUMBER <b>D28221</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAN H. SCHREIER, MD 301 Hospital Drive, Glen Burnie, MD 21061</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


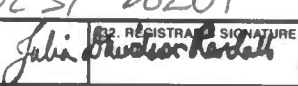
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11427

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA JENKINS</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>4</b> YEAR <b>95</b>		3. TIME OF DEATH <b>555 PM</b>	
4. SOCIAL SECURITY NUMBER <b>238-18-3041</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7 7 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N/A</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>University Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>607 Pennsylvania Avenue</b>	
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Unknown</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Harris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Steward</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FLAINE YOUNG</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>607 Pennsylvania Ave. Baltimore Maryland</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. Zion</b>		20c. LOCATION — City or Town, State <b>4-11 Baltimore</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll 1712 W. North Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>VENTRICULAR ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kath E. McMurphy MD</b>				29c. LICENSE NUMBER <b>P-7757</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/4/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>22 S. GREEN ST 20201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11428

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John C. JENKINS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 13 1995</b>		3. TIME OF DEATH <b>4:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>211-10-9255</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 24, 1917</b>	
8. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE COUNTY</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE COUNTY</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>323 ELINOR AVENUE</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AEROSPACE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MARTIN MARIETTA CORP.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN E. JENKINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH BAXTER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY JENKINS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>323 ELINOR AVENUE BALTIMORE, MARYLAND 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOBELAND MEMORIAL PARK APRIL 17, 1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robson Funeral Home, Inc.</i>				22. NAME AND ADDRESS OF FACILITY <b>LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>3 Days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimers disease</b> <b>Coronary artery disease</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rodney Brooks, M.D.</b>				29c. LICENSE NUMBER <b>043636</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rodney Brooks M.D. 9000 Franklin Square Drive Baltimore, Maryland 21234</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24x1



95 11429

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John Lawrence</i> Sr.				2. DATE OF DEATH MONTH DAY YEAR <i>April 11, 1995</i>		3. TIME OF DEATH <i>4:00 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>220-48-4246</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>45</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 3, 1949</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>North Arundel Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Glen Burnie</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Gambrills</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>1015 April Court</i>				10f. ZIP CODE <i>21054</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1969-72</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <i>Mechanic</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Trucking</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Everett Lawrence</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Wilma Blaaid</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Debbie M. Lawrence</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1015 April Court, Gambrills, MD 21054</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Veterans Cemetery</i>		DATE <i>4/14</i>		20c. LOCATION — City or Town, State <i>Crownsville, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas A. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY <i>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>asphyxiation</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>4/11/95</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>hanging</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>home</i>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Buggs MD</i>				29c. LICENSE NUMBER <i>D28640</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/11/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>556 Cardinal Drive Pasadena MD 2122</i>							
31. DATE FILED (Month, Day, Year) <i>APR 14 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


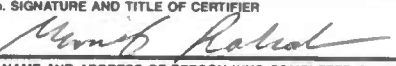
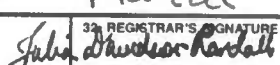




95 11430

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Alexander J. Machin</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-20-0287</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 14, 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2042 GRIFFIS AVENUE</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+) <b>PAINTER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PAINTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ROCK HILL CONSTRUCTION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC MACHIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELLEN BURNETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. JOHN FREEBERGER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2042 GRIFFIS AVENUE - BALTIMORE, MD 21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>4/14</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Complete Heart block</b> DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death <b>15 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>G.I. bleeding</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>15 days</b>
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPertension, Tachycardia - bradycardia syndrome</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D022323864</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Muncif Rahal 900 Caton Ave, Baltimore, MD, 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11431

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>WALTER H. MARTIN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>18:33 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-01-1124</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 15, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Catonsville</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>222 Glenmore Avenue</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W W II</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Herbert Martin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Criddle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arma Martin (Spouse)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>222 Glenmore Avenue Catonsville, Maryland 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery April 15, 1995</b>		20c. LOCATION — City or Town, State <b>Pikesville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Chan Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebral Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>Hours</b> <b>unknown</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David J. Kahan, MD</i>				29c. LICENSE NUMBER <b>D35572</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David J. Kahan, MD Saint Agnes Hospital Balt, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12+1



95 11432

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT VAUGHN MCCURDY</b>				2. DATE OF DEATH <b>APRIL 12 1995</b>		3. TIME OF DEATH <b>8:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-26-0343</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 19, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1055 W. Joppa Road Apt. 203</b>			
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Real Estate Appraiser</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Real Estate</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Roy Earl McCurdy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Mariah Baugh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris McCurdy (Spouse)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1055 W. Joppa Road Towson, Maryland 21204</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (If not cemetery, crematory or other place) <b>Druid Ridge Cemetery April 15, 1995</b>		20c. LOCATION — City or Town, State <b>Pikesville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. G. Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HYPERCARBIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. EMPHYSEMA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Manuel V. Ramos MD</i>				29c. LICENSE NUMBER <b>D38950</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MANUEL RAMOS, MD, 6800 YORK RD, BALTIMORE, MD 21212</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11433

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard E Naumann				2. DATE OF DEATH MONTH DAY YEAR April 11 1995		3. TIME OF DEATH 1223 M	
4. SOCIAL SECURITY NUMBER 578-42-2392		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 11, 1931	
8. FACILITY NAME (If not Institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Churchton	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5555 Gloucester Street			
10f. ZIP CODE 20733				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Systems Technician		16b. KIND OF BUSINESS/INDUSTRY Communications	
17. FATHER'S NAME (First, Middle, Last) James Casper Naumann Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Ruth Henderson			
19a. INFORMANT'S NAME (Type/Print) Mary Ellen Naumann				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5555 Gloucester Street, Churchton, MD 20733			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Cemetery		DATE 4/14		20c. LOCATION — City or Town, State Davidsonville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas A. Henderson</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTING LUNG DISEASE							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. A. Henderson</i>				29c. LICENSE NUMBER D13072		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P996 Woodyard Rd. Churchton, Md.							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE <i>J. A. Henderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11434

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEATRICE E. OBERENDER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>10</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>7:20 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-48-7011</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEBRUARY 23, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE, MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE COUNTY</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE COUNTY</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>12 EAST ELM AVENUE</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSEKEEPING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN DEUCHLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DORA KNABE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MAXINE O. SEYBOTH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 NEW FOREST COURT BALTIMORE, MARYLAND 21286</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MORELAND MEMORIAL PARK APRIL 13, 1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lassahn Funeral Home, Inc.</b>				22. NAME AND ADDRESS OF FACILITY <b>LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Ischemic Cardiac myopathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>HBP and</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>ATSCAD</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death <b>8 to 10 yrs</b> <b>12 yrs</b> <b>10-15 yrs</b> <b>20 yrs</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1st Sarcoma of wall 1964</b> <b>Senile Dementia, Poor Oral Toilet</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael Hyle</b>				29c. LICENSE NUMBER <b>1227693</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Michael Hyle 6530 Walther Ave, Baltimore, Md. 21206</b>							
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Buckner-Radabaugh</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1646-001

B.K.S

ITEMS: 23 PART I, 27 per MEO G-722 4/21/95 reb

95 11435

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>TIEANN L. PETTIES</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>22</b> , YEAR <b>1995</b>				3. TIME OF DEATH <b>9:07 A M</b>	
4. SOCIAL SECURITY NUMBER <b>186-48-7576</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 8, 1957</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL E.R.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>				9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>405 Central Avenue</b>		10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher's Aid</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Kenneth Keyes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alistine Denmark</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Maye Keyes-Venson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1217 S. Sycamore Ave. Los Angeles, Calif. 90019</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Mem. Park March 22, 1995</b>		20c. LOCATION — City or Town, State <b>Cumberland, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ernest A. Ribby, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leasure-Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502</b>					

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):		
	c. DUE TO (OR AS A CONSEQUENCE OF):		
	d. DUE TO (OR AS A CONSEQUENCE OF):		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mark F. Gault Jr. MD</b>		29c. LICENSE NUMBER <b>O.C.M.E</b>	29d. DATE SIGNED (Month, Day, Year) <b>MARCH 23, 1995</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mark F. Gault Jr. MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>			
31. DATE FILED (Month, Day, Year) <b>APR 14 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Bruckner-Kardak</b>	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11436

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OTIS B. READ, JR.				2. DATE OF DEATH MONTH DAY YEAR APRIL 12, 1995		3. TIME OF DEATH 9:36 A. M	
4. SOCIAL SECURITY NUMBER 028-05-1427		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 11, 1910	
9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION LUTHERVILLE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 251 MEADOWVALE ROAD				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERGYMAN		16b. KIND OF BUSINESS/INDUSTRY RELIGIOUS	
17. FATHER'S NAME (First, Middle, Last) OTIS B. READ, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE MacGILLVARY			
19a. INFORMANT'S NAME (Type/Print) MILDRED L READ				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 MEADOWVALE ROAD LUTHERVILLE, MD. 21093			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL CEM. 4/15/95		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ENDSTAGE LIVER FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <u>sev. years.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) APR 14 1995		32. REGISTRAR'S SIGNATURE <i>John E. Dolan</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James H. Roper JR.				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 12:55 A M	
4. SOCIAL SECURITY NUMBER 247-48-2876		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-16-35	
8. FACILITY NAME (If not institution, give street and number) VA Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MD				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1205 WILDWOOD PARKWAY				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 8-18-52 to 11-08-55		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY UNK			
17. FATHER'S NAME (First, Middle, Last) JAMES H. ROPER SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUVENIA COLEMAN			
19a. INFORMANT'S NAME (Type/Print) JEWEL ROPER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 WILDWOOD PKWY. BALTO. MD 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VET. 04-17-95		20c. LOCATION — City or Town, State OWINGS MILLS MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 30 min	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. End Stage Renal Disease DUE TO (OR AS A CONSEQUENCE OF):				6 months	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal, Cerebral Vascular Accident							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MICHELLE E. YOUNG, MD				29c. LICENSE NUMBER MRO 715		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHELLE E. YOUNG, MD				31. DATE FILED (Month, Day, Year) APR 14 1995			
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-2116-510

blh

95 11438

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Daniel Adkins</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 12 1995</b>		3. TIME OF DEATH <b>0650</b> M	
4. SOCIAL SECURITY NUMBER <b>220-76-6472</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32*</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-2-62</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>4700 blk. Haldane Road</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4200 Haldane Rd Apt K</b>		10f. ZIP CODE <b>21206</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Daniel Adkins, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ola B. McKay</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ola B. Hopson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2703 E. Preston St. Balt., MD 21213</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cem 4-15</b>		20c. LOCATION — City or Town, State <b>Catonsville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Karen M. Koger</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. East, Balt., MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SHOTGUN WOUND TO BACK; GUNSHOT WOUND OTHER AND</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. RIGHT LOWER EXTREMITY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>At scene</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4 12 95</b>		28b. TIME OF INJURY <b>0650A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SHOTS FOR</b>		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) <b>STREET</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3700 BLK HALDANE STREET BALTIMORE MD</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Marie DeLue</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Halymon S. KOREN 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIAN ELIZABETH AMPREY				2. DATE OF DEATH MONTH DAY YEAR APRIL 12 1995		3. TIME OF DEATH 145 P M	
4. SOCIAL SECURITY NUMBER 214-12-1240		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 6.1914	
9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTO	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTO		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2544 W. LANVALE ST.				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) 2YRS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY BALTO PUBLIC SCHOOL			
17. FATHER'S NAME (First, Middle, Last) CHARLES JACKSON				16. MOTHER'S NAME (First, Middle, Maiden Surname) IDA JOHNSON			
19a. INFORMANT'S NAME (Type/Print) JOSEPH L. AMPREY SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2544 W. LANVALE ST. BALTO, MD 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) ARBUTUS MEMORIAL PK 41895		DATE APRIL 12 1995		20c. LOCATION — City or Town, State ARBUTUS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Marshall</i>				22. NAME AND ADDRESS OF FACILITY MARCH F/H -WEST 4300 WABASH AVE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PANCREAS CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Paul Kerner				29c. LICENSE NUMBER 226043		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Marshall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11440

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Antonio Alves F.</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>14</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>0700 AM</i>	
4. SOCIAL SECURITY NUMBER <i>123-22-2571</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>79</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>06/13/1915</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>CITY</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>CITY</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>618 S. Washington Street</i>				10f. ZIP CODE <i>21231</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <i>Argentinian</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Seaman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Merchant Marines</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Placido F. Alves</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maria F. (UNKNOWN)</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Helen A. Alves</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>618 S. Washington St. Balto. Md. 21231</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Stanislaus Cem. 4-18</i>		20c. LOCATION — City or Town, State <i>Baltimore City</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY <i>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Massive CVA</i> DUE TO (OR AS A CONSEQUENCE OF): <i>HA SCVD</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i>							Approximate interval Between Onset and Death <i>2 days</i> <i>year</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Navarro M.D. - Specialist</i>				29c. LICENSE NUMBER <i>D 40356</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 14, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>W. NAVARRO 100 N. Broadway, Baltimore, MD. 21231</i>							
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>J. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11441

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HORACE ARMSTRONG</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>239-28-7241</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/11/1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N. CAROLINA</b>		9a. FACILITY NAME (If not institution, give street and number) <b>1701 EUTAW STREET #815</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1701 EUTAW STREET #815</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>REPAIRMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HILLEN TIRE CO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WALTER ARMSTRONG</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BONNIE (Unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GARY ARMSTRONG</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6805 SAUTER LANE BALTIMORE, MD 21207</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 4/13</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Heroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>HEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary artery disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Renal insufficiency</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Anne</i>				29c. LICENSE NUMBER <b>D30641</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ramesh Sabapathi MD Suite 308 821 N. EUTAW ST BALTIMORE, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL BRYANT</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>07</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:00A M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-19-52</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SUBWAY STATION 1111 @ LANDOVER ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LANDOVER</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Riverdale</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6239 64th Avenue</b>			
10f. ZIP CODE <b>20737</b>				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-- If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE -- American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>ocme</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION -- City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>4/07/95</b>		28b. TIME OF INJURY <b>9:39A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) <b>TRAIN/RAIL ROAD</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NEAR LANDOVER RD, LANDOVER MD.</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>[Signature]</i>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 08/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MARIO GOLLE JR, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



asp

95 11443

1 - FOR  
STATE  
REGISTRAR

ITEMS: 23 PART I, 27, 28a, b, c, d, e, f PER MEOG-722 4/21/95 reb

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTIN E. BARNES</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>06</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:22 AM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>39</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>9-27-55</b>		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL ER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>701 W. Mulberry St</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>OCME</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify) <b>in state removable</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655 W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND 4/5/95</b>		28b. TIME OF INJURY <b>found 11:00 P.M.</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN HOUSE</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Desmond J. Chute MD</b>		29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 06, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET BALTIMORE, MARYLAND 2120</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE <b>John P. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11444

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DANIEL BEERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR. 3rd 1995</b>		3. TIME OF DEATH <b>11:55 PM</b>	
4. SOCIAL SECURITY NUMBER <b>116 05 1574</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-23-1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crownsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1454 Fairfield Loop Rd</b>				10f. ZIP CODE <b>21032</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <i>Ronald S Wade</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Respiratory Failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Renal Failure</b> b. <b>Heart Failure</b> c. <b>Chronic obstructive lung disease with exacerbation</b> d. <b>Dehydration</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward N. Sherman M.D.</i>				29c. LICENSE NUMBER <b>D19171</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDWARD N. SHERMAN, M.D./795 AQUAHART ROAD, #203/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2192-510  
B.K.S

95 11445

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT BROWN				2. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1995				3. TIME OF DEATH 1415 P M							
4. SOCIAL SECURITY NUMBER 248-24-6574		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JAN. 10, 1924		8. BIRTHPLACE (State or Foreign Country) S. CAROLINA			
9a. FACILITY NAME (If not institution, give street and number) 1421 EAST EAGER STREET 3RD FL.						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH n/a					
10a. STATE MARYLAND						10b. COUNTY n/a				10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1421 EAST EAGER STREET 3RD FL.						10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) unknown College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER				16b. KIND OF BUSINESS/INDUSTRY UNITED STATES ARMED SERVICES							
17. FATHER'S NAME (First, Middle, Last) ED GASKINS						18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTELLE P. GASKINS									
19a. INFORMANT'S NAME (Type/Print) UYLSSES BROWN						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1968 COLONIAL AVENUE, BURTON, SOUTH CAROLINA									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM. 4-19				20c. LOCATION — City or Town, State OWINGS MILLS, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. E. Holland						22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Dyspepsia		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER M. J. K. M. E.						29c. LICENSE NUMBER O.C.M.E				29d. DATE SIGNED (Month, Day, Year) APRIL 15, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. J. K. M. E. 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) APR 17 1995						32. REGISTRAR'S SIGNATURE John H. H. H.									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


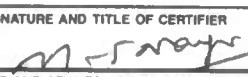





95 11446

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLORENCE W. BILLUPS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR 12 1995</b>		3. TIME OF DEATH <b>0250</b> M	
4. SOCIAL SECURITY NUMBER <b>486 - 28 - 2595</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 16, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Missouri</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>	
10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2025 Woodreeve Road</b>	
10f. ZIP CODE <b>20782</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, OIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Public Schools</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Hugh White</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virginia Davis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Karle Billups Booser</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2025 Woodreeve Road, Hyattsville, Maryland 20782</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Grove Cemetery</b>		20c. LOCATION — City or Town, State <b>4/15 St. Louis, Missouri</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE UROSEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>8 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D-17874</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S.M. NYAR, 3717 38th AVE BRIGHTWOOD, MD 20722</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2181-009  
BKS

95 11447

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DENNIS ALLEN BOLLINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>04 13 1995</b>		3. TIME OF DEATH <b>3:00 PM</b>			
4. SOCIAL SECURITY NUMBER <b>212 - 50 - 3092</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 7, 1952</b>			
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PRINCE FREDERICK</b>			
9c. COUNTY OF DEATH <b>CALVERT</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>			
10c. CITY, TOWN OR LOCATION <b>Jessup</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8207 Cambridge Court</b>			
10f. ZIP CODE <b>20794</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3 Years</b> College (1-4 or 5+) <b>3 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Concrete Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Glenn Bollinger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Charlotte Baker</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Debra L. Bollinger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8207 Cambridge Court, Jessup, Maryland 20794</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Cem. 4/18</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 14, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11448

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS BLUEFORD				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 11:05 P M	
4. SOCIAL SECURITY NUMBER 218-18-2057		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 21, 1925	
8a. FACILITY NAME (If not Institution, give street and number) PARK MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1225 HOLLINS STREET				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES XX		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) n/a				18. MOTHER'S NAME (First, Middle, Maiden Surname) n/a			
19a. INFORMANT'S NAME (Type/Print) MR. GOLDBAUM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 eutaw place, BALTIMORE, MARYLAND 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 4-14		20c. LOCATION - City or Town, State CATONSVILLE, MD		20d. DATE 4-14	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Bronchogenic Carcinoma</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>with Metastases</u> c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 12-19528		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ELMO M. GAYSON 5411 Old Frederick Rd. Balto. 21229							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11449

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AQUA M. BRIGGS-HALL				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995		3. TIME OF DEATH 2:20A M					
4. SOCIAL SECURITY NUMBER 217-33-3632		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 3 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/03/1991		8. BIRTHPLACE (State or Foreign Country) MD.			
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH CITY				
10a. STATE MD.				10b. COUNTY CITY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 507 N. Rock Glen Rd.				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		15b. KIND OF BUSINESS/INDUSTRY N/A							
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LaToya (Unknown)							
19a. INFORMANT'S NAME (Type/Print) Tom Famulari				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 N. Rock Glen Rd. Baltimore Md. 21229							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Carmel Cemetery 4-18			20c. LOCATION — City or Town, State Baltimore City						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Aspiration</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Dysfunctional Swallow</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Cerebral Palsy</u>  Approximate Interval Between Onset and Death 4 days 4 days 3 yrs 3 yrs								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Mental Retardation</u> <u>Alcohol's Syndrome</u>								25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Clemens</i> Pediatric Resident				29c. LICENSE NUMBER AJ4147357MO343		29d. DATE SIGNED (Month, Day, Year) 04-15-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher T. Clemens, MD 600 N Wolfe St. Balt. MD 21287											
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


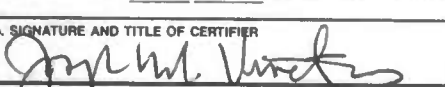





95 11450

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VALERIE BARBER</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>138-56-4297</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04 06 61</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bayview Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>NA</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2002 Winford Road</b>			
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accounting</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DEPT. OF SOCIAL SERVICES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Olin Barber</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn Barber (William)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Olin Barber</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2002 Winford Road Balto, MD 21239</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park 4/20/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Unity Funeral Home 108 W. North Ave. Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Uremia</b>				Approximate interval between Onset and Death <b>1 week</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>acquired immune deficiency syndrome</b>				5 years	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER <b>D45746</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph M. Viretz MD Johns Hopkins Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Beverly Baldwin</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1734</b> M	
4. SOCIAL SECURITY NUMBER <b>267-56-0442</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/13/41</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Florida</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Gen.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>	
9c. COUNTY OF DEATH <b>AA</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Crofton</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1735 Dana Street</b>	
10f. ZIP CODE <b>21114</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify:				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8+</b> College (1-4 or 5+) <b>8+</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nursing Professor</b>				16b. KIND OF BUSINESS/INDUSTRY <b>University of Maryland</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Noel Douglas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Malzie Crutchfield</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Douglas Baldwin</b> (BROTHER) (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>368 Rapidan Park Conroe, Texas 77302</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Holly Hill Cemetery April 17, 1995</b>			
20c. LOCATION — City or Town, State <b>Port St. Joe, Florida</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lussuean Witzke</b>			
22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiac Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASTHMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Exogenous Obesity</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>4/13/95</b>			
28b. TIME OF INJURY M <b>1</b> YES 2 <input type="checkbox"/> NO				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William P. Jones MD Deputy</b>				29c. LICENSE NUMBER <b>D06054</b>			
29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones MD 695 America 21035</b>			
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>Johi Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11452

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARLENE JAN BOONE				2. DATE OF DEATH MONTH DAY YEAR APRIL 8, 1995		3. TIME OF DEATH 10:50 P.M.	
4. SOCIAL SECURITY NUMBER 212-44-5512		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. 50	7. DATE OF BIRTH (Month, Day, Year) 10/18/44		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD.	
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH CITY	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 2559 W. FAIRMOUNT AVE,				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: ARF. AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN			
17. FATHER'S NAME (First, Middle, Last) JOHN BOONE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL BOONE			
19a. INFORMANT'S NAME (Type/Print) JEANNETTE STAR GREGORY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2559 W. FAIRMOUNT AVE, BALTIMORE, MARYLAND 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK 4/13/95		20c. LOCATION — City or Town, State ARBUTUS, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sheryl M. Estep</i>				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CON PULMONALE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PULMONARY FIBROSIS</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>SARCIDOSIS</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 yr 5 yr 25 yr							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC AORTIC DISSECTION; COAGULOPATHY</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Not determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D18642		29d. DATE SIGNED (Month, Day, Year) 4/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. CARCAMENT, M.D. 5518-B PHILA RD. BALT, MD. 21237							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>JANET C. BLANKNEY</del> JANET C. BLAKNEY		2. DATE OF DEATH MONTH 03 DAY 30 YEAR 95		3. TIME OF DEATH 3:30 P.M.
4. SOCIAL SECURITY # <del>088-03-5661</del> 218-56-0052 SEX M		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/14/52
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY OF MARYLAND		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MARYLAND		9c. COUNTY OF DEATH BALTIMORE
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2030 BOYD ST		10f. ZIP CODE 21223
10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11+ <sup>th</sup> GRADE College (1-4 or 5+) College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY N/A		17. FATHER'S NAME (First, Middle, Last) CHARLES WILSON
18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS FERGUSON		19a. INFORMANT'S NAME (Type/Print) MONICA BLAKNEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 S. CULVER ST., BALTIMORE, MD. 21229
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 4-4-95		20c. LOCATION — City or Town, State BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph H. Brown Jr.</i>		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death 4 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HIV positive</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 3/26/95		28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER RESIDENT		29c. DATE SIGNED (Month, Day, Year) 3/30/95
29d. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Del Pizzo MD</i>		29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH DEL PIZZO, M.D., UNIVERSITY OF MD., 22 S. GREENE, ST 21301		
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ELIZABETH BURGEOYNE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 12, 1995</b>				3. TIME OF DEATH <b>1:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-10-8422</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 10, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>5311 Plymouth Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5311 Plymouth Road</b>				10f. ZIP CODE <b>21214</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Can Manufacturing Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William H. Roberts</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Delma MNM Middleton</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Jane Elizabeth Cullum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5311 Plymouth Road, Baltimore, Maryland 21214</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial 4/15</b>				20c. LOCATION — City or Town, State <b>Timonium, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kathleen M. Murphy</b>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>TERMINAL CANCER</b> <b>BRAIN CANCER</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death <b>2 1/2 yrs.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HCV D</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James M. [Signature] M.D.</b>				29c. LICENSE NUMBER <b>D17148</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-13-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>4706 HARBOR RD, BALTO, MD 21214</b>									
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		REGISTRAR'S SIGNATURE <b>Jane [Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 11 15


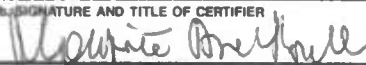
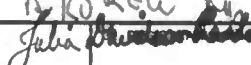
95-2198-005  
blh

95 11455

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael Carter</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 15 1995</b>		3. TIME OF DEATH <b>0305</b> M					
4. SOCIAL SECURITY NUMBER <b>220-32-9592</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 5 35</b>		8. BIRTHPLACE (State or Foreign Country) <b>England</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Jarrettsville Pike-(S) of Manor Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Jarrettsville</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Jarrettsville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4053 Norrisville Rd.</b>				10f. ZIP CODE <b>21084</b>		10g. CITIZEN OF WHAT COUNTRY? <b>England</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Landscaper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Landscaping</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Frederick Carter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucy Whybourn</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Lucy Carter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5618 Woodmont Ave #D Balt. Md. 21239</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Co. April 17 1995</b>		DATE <b>April 17 1995</b>		20c. LOCATION — City or Town, State <b>Towson Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home 1050 York Rd. Towson Md. 21204</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MULTIPLE TRAUMAS</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4 15 95</b>		28b. TIME OF INJURY <b>0054A</b> M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>CAR DRIVER IN IMPACT WITH ANOTHER CAR</b>			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>JARRETTSVILLE PIKE. BALTIMORE COUNTY</b>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 15 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARGARITA A. KORSUN 111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b> 											

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11456

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dryce Cowsill</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>10</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>115pm</i>	
4. SOCIAL SECURITY NUMBER <i>212 60 5451</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>43</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <i>7-31-1951</i>				8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>na</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>na</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>702 E. Fort Avenue</i>				10f. ZIP CODE <i>21230</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i>11</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Telephone Operator</i>				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>James Cowsill</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Janet Thomas</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Tod Cowsill</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1627 Webster St, Balto, MD 21230</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655W. Baltimore, St, Balto, MD 21201</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atherosclerotic Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <i>3 days</i> <i>10 yrs</i> <i>3 yrs</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>David Hexter</i> 29b. SIGNATURE AND TITLE OF CERTIFIER <i>DAVID HEXTER, MD</i>		29c. LICENSE NUMBER <i>D38861</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/11/95</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DAVID HEXTER, MD HARBOR HOSPITAL CENTER</i>			
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia Stinson-Rodell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH REG. NO.

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>Eva P. Connor</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1995</b>				3. TIME OF DEATH <b>12:30 A M</b>															
4. SOCIAL SECURITY NUMBER <b>216 10 6977</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>01 19 12</b>		IF UNDER 24 HRS. HOURS MIN. <b>01 19 12</b>		7. DATE OF BIRTH (Month, Day, Year) <b>01 19 12</b>													
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Bay View Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>											
10a. STATE <b>Md.</b>												10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Harbor View</b>				10d. INSIDE CITY LIMITS? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>			
10e. STREET AND NUMBER <b>620 S. 47th. Street</b>								10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b> <b>College (1-4 or 5+) 6</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Clothing</b>															
17. FATHER'S NAME (First, Middle, Last) <b>James Slowikowski</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Antouinette (Unknown)</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Robert A. Connor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>620 S. 47th. St. Balto., Md.</b>																			
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 4-15-95</b>				20c. LOCATION — City or Town, State <b>Eastwood, Md.</b>															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles S. Zeiler</b>				22. NAME AND ADDRESS OF FACILITY <b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave. Balto., Md.</b>																			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Probable Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>												Approximate Interval Between Onset and Death <b>&lt; 1 hr</b> <b>1 wk</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes mellitus, hypertension, history MI</b>												24a. WAS AN AUTOPSY PERFORMED? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>																							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>																			
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		28d. DESCRIBE HOW INJURY OCCURRED													
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																			
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>																							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>original signed by Dr. Graham Dike</b>				29c. LICENSE NUMBER <b>AP 2664200-157</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 11, 1995</b>															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G. Dike // by [signature] Johns Hopkins Bayview Medical Center 4940 Eastern Avenue, Baltimore Md 21224</b>																							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>[signature]</b>																			





95 11458

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ALICE LILLIAN CRESTA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 15 1995</b>		3. TIME OF DEATH <b>10:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-22-9492</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-26-1926</b>	
8. FACILITY NAME (If not institution, give street and number) <b>3415 Cornwall Rd</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>		10. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>825 S. Kenwood Ave</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bartender</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Saloon</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Siebert</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Dembeck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Yvonne Shirk</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3415 Cornwall Rd Baltimore, Md 21222</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 4-18</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony Edt Connelly</i>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cancer of small bowel</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Flinn, M.D.</i>				29c. LICENSE NUMBER <b>D44629</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/17/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ian Flinn, M.D. 600 N. Wolf Street Baltimore, Md. 21287</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AKA ELIZABETH GENORA CALLAHAN <b>ELIZABETH G. CALLAHAN</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>12:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-26-6400</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 30, 1903</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>NA</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore (Westport)</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2238 Sidney Avenue</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Housewife</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward Kinnamont</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>INFORMATION UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Atty. Arthur L. Drager</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Light St., Baltimore, Maryland 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Pk. 4/15/95</b>		20c. LOCATION — City or Town, State <b>Elkridge, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>				22. NAME AND ADDRESS OF FACILITY <b>McCuilly Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Large left hemispheric stroke</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b> <b>Bilateral aspiration pneumonia</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kamal S. Dauphino</b>				29c. LICENSE NUMBER <b>D18362</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>							
REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Howard J. Deloach</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>21:42 M</b>	
4. SOCIAL SECURITY NUMBER <b>214-68-4471</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 22, 1954</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BAYVIEW HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3050 EDMONDSON AVENUE</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>HIS HIGH SCHOOL DIPLOMA</b> College (1-4 or 5+) <b>DISABLED Laborer</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Various Jobs LABORER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM GREEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORENCE DELOACH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FLORENCE DELOACH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3050 EDMONDSON AVENUE, N. BALTIMORE, MD 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEM. 4-15</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD</b>		20d. DATE <b>4-15</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>fungal endocarditis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>prosthetic aortic valve</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>6 wks</b> <b>&gt;1yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>renal failure, liver failure.</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sonye K. Danoff, M.D.</b>				29c. LICENSE NUMBER <b>LS124</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sonye K. Danoff Bayview Medical Center</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11461

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Brona M. Darden				2. DATE OF DEATH MONTH DAY YEAR April 11 1995		3. TIME OF DEATH 2:40 a.m.	
4. SOCIAL SECURITY NUMBER 579 - 12 - 3122		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 26, 1917	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) Mariner Nursing & Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Laurel	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 14800 4th Street #23C	
10f. ZIP CODE 20707				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Purchasing Agent		16b. KIND OF BUSINESS/INDUSTRY Art Gallery	
17. FATHER'S NAME (First, Middle, Last) Luther Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ola Pead			
19a. INFORMANT'S NAME (Type/Print) Shirley Ann Soper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Greenhill Avenue, Laurel, Maryland 20707			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 4/13		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>acute myocardial infarction</u> minute							
b. <u>coronary artery disease</u> years							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER MD2767		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chris Manik MD 8917 CWM Lane Laurel MD 20707							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sonia Dardarian</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 14 1995</b>		3. TIME OF DEATH <b>2:00am</b> M	
4. SOCIAL SECURITY NUMBER <b>116-07-4777</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 27 1908</b>	
8a. FACILITY NAME <b>Rivers Edge</b> <b>7138 Riversedge Rd.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		8c. BIRTHPLACE (State or Foreign Country) <b>Turkey</b>	
9a. COUNTY OF DEATH <b>Howard</b>				9b. COUNTY OF DEATH <b>Howard</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7138 Riversedge Rd.</b>				10f. ZIP CODE <b>21044</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>unknown- 12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary Seamstress</b>		15b. KIND OF BUSINESS/INDUSTRY <b>self employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Percival (Parsegh) Sherinian</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown Ohsana</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Andrew A. Monjan</b>				19b. MAILING ADDRESS (Route Number, City or Town, State, Zip Code) <b>7138 Riversedge Rd. Col. Md. 21044</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Lawn Mem. Pk. 4-21-95 Cypress Ca.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>M00544</b> <b>Allen Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A.</b> <b>Ellicott City, Md 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>Yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCUD</b> <b>CAD</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Flanagan J H E C</b>				29c. LICENSE NUMBER <b>1724334</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/14/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Flanagan J H E C</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>Alii Dardarian</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

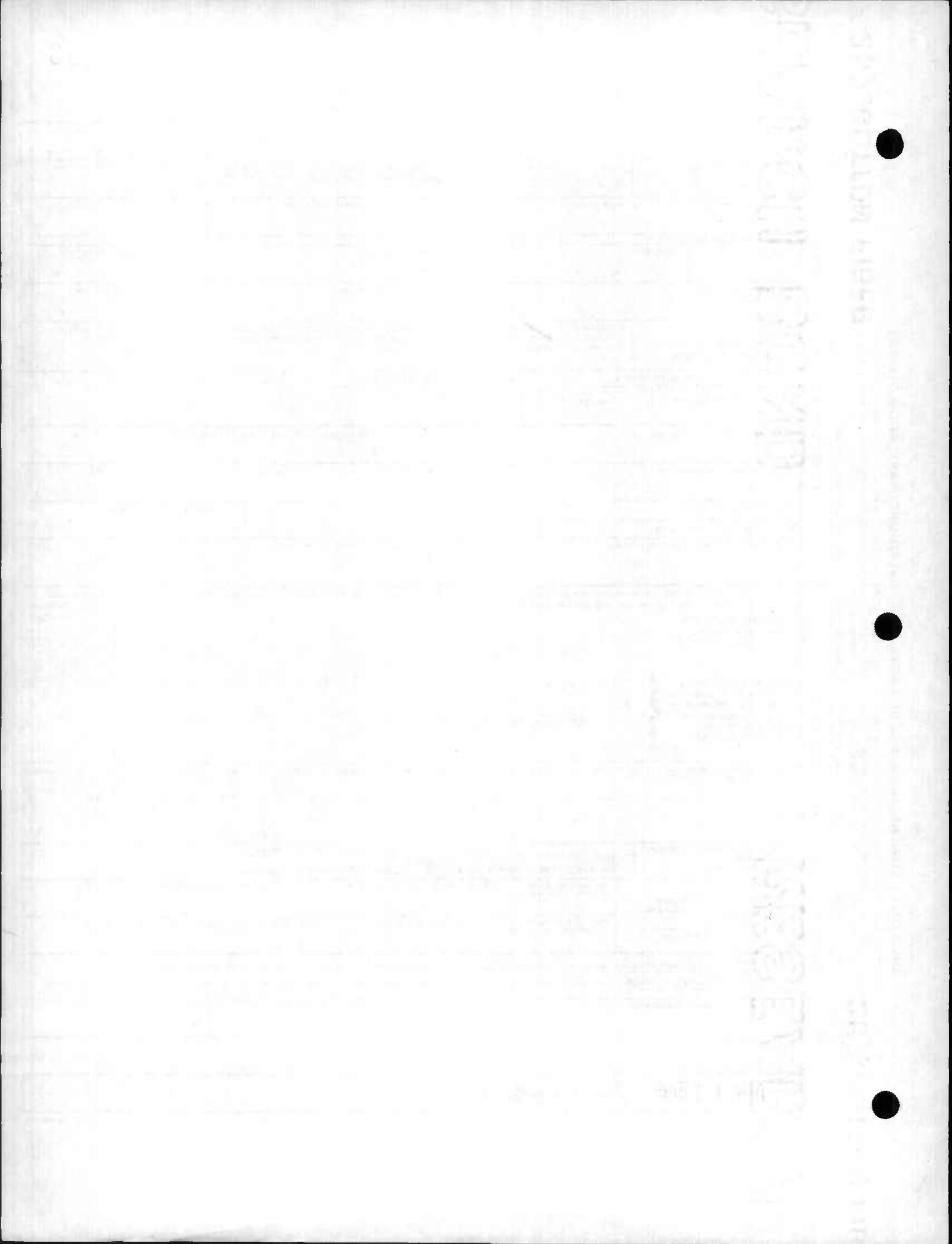
1. DECEDENT'S NAME (First, Middle, Last) <b>JACQUELINE DELOATCH</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:10 A M</b>					
4. SOCIAL SECURITY NUMBER <b>579-42-6012</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 22 1935</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>				9c. COUNTY OF DEATH <b>Howard</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>9081 Gold Amber Garth</b>				10f. ZIP CODE <b>21045</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1954-1956</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+) <b>2+</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Samuel L. Dean</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Althea Leary</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Jovita DeLoatch</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2336 Market St. Suite 110 San Francisco Ca. 94114</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Mem. Gdns 4-15-95</b>		20c. LOCATION — City or Town, State <b>Marriottsville Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Moo544</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P. A. Ellicott City, Md. 21043</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic adenocarcinoma involving peritoneum</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>8 months</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Matilda H. So, MD</b>				29c. LICENSE NUMBER <b>D26250</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MATILDA H. SO, 1447 YORK RD, LUTHERVILLE, MD 21093</b>											
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John H. ...</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 11464

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN RITA DIETZ</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>02:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219 05 4632</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01 25 19</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3542 Juneway</b>	
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Exxon Corp.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Albert F. Dietz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. Buettner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Geraldine M. Palese</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8800 Walther Blvd. Apt. 1420 Balto., Md. 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cem. 4-17-95 Dundalk, Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles S. Zeiler</b>				22. NAME AND ADDRESS OF FACILITY <b>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St. Balto., Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC CARCINOMA OF LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death <b>1 YR</b> <b>1 YR</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARCINOMA OF THE COLON</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Addo MD.</b>				29c. LICENSE NUMBER <b>046845</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 13, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN ADDO, 5601 LOCH RAVEN BLVD, BALT, MD 21239</b>							
31. DATE OF DEATH <b>APR 17 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11465

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPHINE DELUCA</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>14</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:30 A</b> M	
4. SOCIAL SECURITY NUMBER <b>215-09-5716</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 19, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>CITY</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6224 Woodcrest Avenue</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CITY</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Daniel Marshall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Busciacco</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nicholas De Luca</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21209</b> <b>6224 Woodcrest Avenue, Baltimore, Maryland</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial 4/14</b>		20c. LOCATION — City or Town, State <b>Cockeysville, MD</b>		20d. DATE <b>4/14</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nym Burgee Henss</i>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 21211</b> <b>3631 Falls Road, Baltimore, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Exsanguination from Ruptured Aortic Abdominal Aneurysm</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Hypertensive Cardio Renal Vascular Dis</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell MD</i>				29c. LICENSE NUMBER <b>1-09383</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell MD - 111 Hamlet Hill Rd - Cockeysville, MD 21210</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Zeneldria Everett</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>13</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:30 a m</b>	
4. SOCIAL SECURITY NUMBER <b>215-72-2329</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 9, 1959</b>	
8. BIRTHPLACE (State or Foreign Country) <b>md</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>md</b>			
10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2406 Loyola Northway apt 204</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Unknown</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Howard Coles</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Woodridge</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rose Coles</b>				19b. MAILING ADDRESS <b>2525 Reisterstown Rd. Balto, md 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Pk 4/14/95</b>		20c. LOCATION — City or Town, State <b>Randallstown, md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Chron</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. - West 4300 Wabash Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Thrombocytopenia</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James Elderms House officer</b>				29c. LICENSE NUMBER <b>038993</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James Elderms 2600 liberty Hgts Baltimore MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jahia Hudson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11467

ITEM: 23 PART I, PER DR. FILM G-726 8/10/95 t.t

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MYRHLE E. EVANS				2. DATE OF DEATH MONTH DAY YEAR April 17 1995		3. TIME OF DEATH 5:00 A M	
4. SOCIAL SECURITY NUMBER 213-10-3167		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	7. DATE OF BIRTH (Month, Day, Year) 11-2-1900		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 7550 Ives Lane				9b. CITY, TOWN OR LOCATION OF DEATH Dundalk		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7550 Ives Lane				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing			
17. FATHER'S NAME (First, Middle, Last) Morris Hildrich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Katherine Myers			
19a. INFORMANT'S NAME (Type/Print) Ella Carney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7550 Ives Lane Baltimore, Md 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 4-19		20c. LOCATION — City or Town, State Baltimore, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony C. Connelly</i>				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Hypertension</i> HYPERTENSION CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 3 months 3 years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raymundo S. Magno MD</i>				29c. LICENSE NUMBER <i>00930</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/17/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Raymundo S. Magno, M.D. 7811 Wise Ave Baltimore, Md 21222							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11468

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN M. EVELYN MARGARET ETHERIDGE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 11, 1995</b>		3. TIME OF DEATH <b>3:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-07-4607</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 3, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>NA</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore (Brooklyn)</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1315 Church St.,</b>				10f. ZIP CODE <b>21226</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker and Mother</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Housewife</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edwin Jefferies</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Adelman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Jeffery Michael Etheridge</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6435 Orchard Rd., Linthicum, Md. 21090</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery 4/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>SEPTIC SHOCK</b>				Approximate Interval Between Onset and Death <b>12 DAYS</b>	
		b. <b>INFARCTED SMALL BOWEL</b>				<b>22 DAYS</b>	
		c. <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				<b>8 YRS.</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ronald A. Covar, MD</b>				29c. LICENSE NUMBER <b>MS-2441614-29</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RONILDA A. COVAR, MD 3001 S. HANOVER ST., BALTIMORE MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John M. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENYON				2. DATE OF DEATH MONTH DAY YEAR APRIL 11 95				3. TIME OF DEATH 5:40 P.M.							
4. SOCIAL SECURITY NUMBER 220-86-0365		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 18 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) OCT. 14, 1976		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD					
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH n/a							
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 5925 YORKWOOD ROAD				10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER				16b. KIND OF BUSINESS/INDUSTRY RESTAURANT							
17. FATHER'S NAME (First, Middle, Last) ULYSSES FEATHSTONE				18. MOTHER'S NAME (First, Middle, Maiden Surname) VICTORIA MATTHEWS											
19a. INFORMANT'S NAME (Type/Print) VICTORIA MATTHEWS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5925 YORKWOOD ROAD, BALTIMORE, MD 21239											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK 4-19				20c. LOCATION — City or Town, State ARBUTUS, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Koger				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND TO BACK DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 4 11 95		28b. TIME OF INJURY 1716 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED GUNSHOT WOUND					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1700 BLK CARSWATER BALTIMORE MD							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Monique D. Smith		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maryson A. Korte 111 PENN STREET BALTIMORE, MARYLAND 21201															
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodell											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11470

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTHEW W. FORRESTER SR.</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:43 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-30-1001</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 27, 1935</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE, MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1027 cathedral street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1027 CATHEDRAL STREET APT. 17H</b>	
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>12 TH</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SANITATION LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE CITY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT C. FORRESTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAYBELLE GREGG</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GENEVIEVE MOORE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1903 E. BELVEDERE AVENUE, BALTIMORE, MD 21239</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK 4-18</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Karen M. Koger</b>	
22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>FATTY LIVER</b>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <b>PARTIAL</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wayne Dorey</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYNORA P. KOREN MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



95 11471

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William F. Frey</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>16</i> YEAR <i>95</i>		3. TIME OF DEATH <i>6:18 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-09-6258</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 4 1917</i>	
9a. FACILITY NAME (If not Institution, give street and number) <i>University Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Kent</i>		10c. CITY, TOWN OR LOCATION <i>Chestertown</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>Rt. 1 Box 217 Marganser Dr.</i>			
10f. ZIP CODE <i>21620</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>4th</i>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Manager</i>		17. KIND OF BUSINESS/INDUSTRY <i>ACME PAD CORP.</i>	
17. FATHER'S NAME (First, Middle, Last) <i>William Howard Frey</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ida Coleman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Hazel May Frey</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Rt. 1 Box 217 Marganser Dr. Chestertown Md. 21620</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Cem. 4-20-95</i>		20c. LOCATION — City or Town, State <i>Glen Burnie Md.</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Allen Smith</i> M00544	
22. NAME AND ADDRESS OF FACILITY <i>Slack Funeral Home, P. A. Ellicott City, Md. 21043</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew E. Myers MD</i>		29c. LICENSE NUMBER <i>P08624</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/16/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ANDREW E. MYERS MD</i>							
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Andrew Radell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

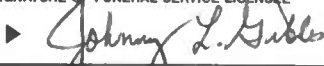
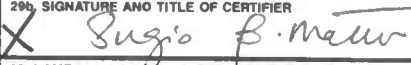

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Junius Andrew Fields, Sr.</b> <b>Junius A. FIELDS</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:37 A M</b>	
4. SOCIAL SECURITY NUMBER <b>436-14-5207</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 20, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Louisiana</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1706 Kirkland Road</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 Years</b> College (1-4 or 5+) <b>Machine Operator</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machine Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Neuville Joseph Fields</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nora Annie Guidry</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ronald R. Fields</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1055 Lido Drive Annapolis, MD 21401</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 4/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>1.5 weeks</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>RD 1654</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sergio Mateo M.D., 9000 Franklin Square Drive Baltimore, Maryland 21234</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1



95 11473

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ZACHARY GLADDEN</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:51 P.M.</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>38</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>1-28-1957</b>		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <b>Church Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>na</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2404 E. Chase Street</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PNEUMOCOCCAL PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. PNEUMOCOCCAL BACTEREMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>3 DAYS</b> <b>36 HOURS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INTRAVENOUS DRUG USE</b> <b>HISTORY OF SPLENECTOMY</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Schlabach</i>				29c. LICENSE NUMBER <b>D41676</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>218 HERITAGE DRIVE, BALTIMORE MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

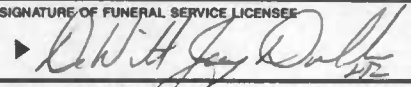
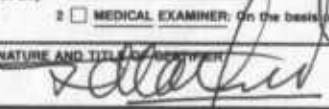
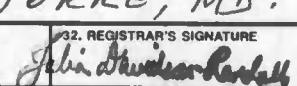




95 11474

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Edward Grimes</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>11</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>5:30 a m</b>	
4. SOCIAL SECURITY NUMBER <b>578 - 09 - 0001</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		8. AGE (in yrs. last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
6a. FACILITY NAME (If not institution, give street and number) <b>422 Barbersville Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Laurel</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>422 Barbersville Road</b>				10f. ZIP CODE <b>20724</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>USA</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>Grade 6</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Repairman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Television Repair</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosemary unknown</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Marcellene Grimes</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>422 Barbersville Road, Laurel, Maryland 20724</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park 4/13 Dorsey, Maryland</b>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic bone disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Prostate cancer</b> <b>Anemia</b>								Approximate Interval Between Onset and Death <b>6 mths</b> <b>4 years</b> <b>4 mths</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: In the base of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D-01966</b>		29d. DATE SIGNED (Month, Day, Year) <b>04-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.A. DE LA TORRE, MD. 320 Montgomery St - Laurel, Md 20707</b>									
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11475

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Christopher James Gross				2. DATE OF DEATH MONTH DAY YEAR APR 16, 1995		3. TIME OF DEATH 7:25 PM M	
4. SOCIAL SECURITY NUMBER 568-33-8968		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 26, 1959	
8. BIRTHPLACE (State or Foreign Country) Michigan				9a. FACILITY NAME (If not institution, give street and number) Seton Hill Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Woodlawn				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 77 Yardley Court	
10f. ZIP CODE 21244				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (14 or 5+) _____			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Mechanic				16b. KIND OF BUSINESS/INDUSTRY Diesel Engines			
17. FATHER'S NAME (First, Middle, Last) Franz X. Gross				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sonja Anna Moessner			
19a. INFORMANT'S NAME (Type/Print) Franz X. Gross				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8125-C Island View Cr. Huntington Beach, CA 92646			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 04/17/95			
20c. LOCATION — City or Town, State Baltimore, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George E. MacNabb</i> George E. MacNabb			
22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acquired Immune Deficiency Syndrome</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Paikh</i> attending physician				29c. LICENSE NUMBER D32158			
29d. DATE SIGNED (Month, Day, Year) 4/17/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jyoti Paikh MD 821 N Eutaw St, Suite 407 Baltimore MD 21201			
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John A. Henderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



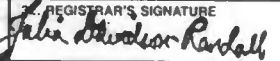
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE G. GORDES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 13 1995</b>		3. TIME OF DEATH <b>5:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>216-46-8630</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 12 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Cromwell</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8643 Richmond Ave.</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6 yrs</b> College (14 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Ellenberger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Hengenmuller Hengenmuhle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Henry W. Gordes</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>911 Rappaix Ct. Baltimore, Md. 21286</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park 4-15</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>congestive heart failure</b>							Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Walter B. Koppel M.D.</b>				29c. LICENSE NUMBER <b>D1538</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter B. Koppel, M.D. 1900 E. Northern Pkwy #207 Balto. MD. 21239</b>							
31. DATE (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is missing, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11477

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Clyde B. Garrison</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 13, 1995</i>		3. TIME OF DEATH <i>2353 PM</i>	
4. SOCIAL SECURITY NUMBER <i>214-38-7665</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>54 YRS.</i>		7. DATE OF BIRTH (Month, Day, Year) <i>Aug 4, 1940</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Bay View Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEASED							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Balto.</i>		10c. CITY, TOWN OR LOCATION <i>Balto.</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1953 Dineen Drive</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (14 or 5+) <i>Chaffee</i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Chaffee</i>		16b. KIND OF BUSINESS/INDUSTRY <i>B.G.E.</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Peter Garrison</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Eva Doss</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Michael C. Garrison</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>405 Grovethorne Rd. Balto., Md. 21220</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Greenmount Crematory</i>		DATE <i>4/15</i>		20c. LOCATION — City or Town, State <i>Balto., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tammy Olsen Utter MD</i>				29c. LICENSE NUMBER <i>D40170</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/14/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Tammy Olsen Utter MD 9105 Franklin Square Drive Baltimore MD 21237</i>							
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11478

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret D. Gable				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 3:50 P M	
4. SOCIAL SECURITY NUMBER 213-10-3607		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 26, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Ruxton	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY CITY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4300 N. Charles Street	
10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2+ College (1-4 or 5+) 2+	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) T. Howard Dail	
18. MOTHER'S NAME (First, Middle, Maiden Surname) May Givens				19a. INFORMANT'S NAME (Type/Print) Robert L. Gable		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Sunset Rock Rd. Andover, MA 01810	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. 4/13		20c. LOCATION — City or Town, State Cockeysville, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jenny Henss Carpenter	
22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease 10 yrs DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right Sided Heart Failure Cellulitis				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D33847	
29d. DATE SIGNED (Month, Day, Year) 4/11/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Vissing 4300 N. Charles St. Apt. 5G Balto., MD 21218		31. DATE FILED (Month, Day, Year) APR 17 1995	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11479

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE WALTER HARIG</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>2</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:30A</b> M	
4. SOCIAL SECURITY NUMBER <b>213 12 6333</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-2-95</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Welcome Center (Rest Area)</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Price</b>	
9c. COUNTY OF DEATH <b>Queen Anne</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>	
10c. CITY, TOWN OR LOCATION <b>Lansdown</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1942 Victory Drive</b>	
10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Butcher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food</b>	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Dorothy Harig</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>149 Stevenson Lane, Baltimore, MD 21212</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>in state removal</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655 W. Baltimore, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. RALPH LIBBY</b>				29c. LICENSE NUMBER <b>205754</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>DR. RALPH LIBBY po box 458, Grasonville, MD 21638</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Hudson Carroll</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS ROYAL HAYNER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>14</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>562-07-2465</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 27, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New Mexico</b>				9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore Towson</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1113 Gypsy Lane West</b>	
10f. ZIP CODE <b>21286</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemical Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Franklin Mitchel Hayner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie Tate</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernetha F. Hayner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1113 Gypsy Lane West, Towson, MD 21286</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>	
22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Myocardial infarction</b> b. c. d.  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert Stoltz, MD</b>				29c. LICENSE NUMBER <b>D30910</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/14/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Stoltz 1447 York Rd. Lutherville, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Andrew Ricketts</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11481

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGETTE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>15</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>12:34A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-54-4171</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/8/1951</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>28 S. Curley St.</b>				10f. ZIP CODE <b>21224</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 6+) <b>Unk.</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Underwriter</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>				17. FATHER'S NAME (First, Middle, Last) <b>George McCormick</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lorraine Kahler</b>				19a. INFORMANT'S NAME (Type/Print) <b>Joseph Hajek</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28 S. Curley St. Baltimore, MD 21224</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cem. 4/19</b>				20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>B. Dabrowski &amp; Son Funeral Home 2818 E. Baltimore St. Baltimore, MD 21224</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTIC SHOCK</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>FUNGAL PNEUMONIA</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>ACUTE MYELOGENOUS LEUKEMIA</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FLUTTER</b> <b>ACUTE RENAL FAILURE</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>M 9273</b>				29d. DATE SIGNED (Month, Day, Year) <b>04.15.95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>600 N WOLFE ST BALTIMORE MD 21287</b>				31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11482

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES NELSON HAWKINS SR.				2. DATE OF DEATH MONTH DAY YEAR 4 - 10 - 95		3. TIME OF DEATH 7:40 a m	
4. SOCIAL SECURITY NUMBER 214-40-8088		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/13/41	
8a. FACILITY NAME (If not institution, give street and number) 2 DUNBAR AVE.				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTO. CO.	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY BALTO. CO.		10c. CITY, TOWN OR LOCATION CATONSVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2 DUNBAR AVE.				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AUTO WORKER		16b. KIND OF BUSINESS/INDUSTRY GENERAL MOTORS			
17. FATHER'S NAME (First, Middle, Last) ARTHUR HAWKINS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA W. HAWKINS			
19a. INFORMANT'S NAME (Type/Print) CARMEN HAWKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DUNBAR AVE. CATONSVILLE MD 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEM. 4/15/95		DATE		20c. LOCATION — City or Town, State BALTO. MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carmen Hawkins</i>				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Dementia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Retroviral Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 months 5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joel E. Gallant MD</i>				29c. LICENSE NUMBER D38398		29d. DATE SIGNED (Month, Day, Year) 4-14-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joel E. Gallant, MD, MPH. 600 N. Wolfe St, Carnegie 292, Balto, MD 21287							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John A. Sullivan-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Claude T. Hall</b>				2. DATE OF DEATH MONTH <b>9</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>216-74-7060</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-10-57</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MED. CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>A.A. CO.</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>A.A.</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>7855 LEVY CT.</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLE</b>		15b. KIND OF BUSINESS/INDUSTRY <b>AA CO. BOARD OF ED.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CLARENCE E. HALL SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HAZEL A. HALL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DIANE HALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>638 HALLMARK DRIVE GLEN BURNIE MD 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CHURCH CEM. 4/14/95</b>		20c. LOCATION — City or Town, State <b>PASADENA, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acquired Immune Deficiency Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>2 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia, organism unknown</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>012452</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>900 Bestgate Rd, Suite 300 Annap. MD 21401</b>							
31. DATE (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11484

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ONELL HARVELL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:45P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-2867</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 26, 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>LONG GREEN NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4632 MARBLE HALL ROAD</b>	
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SEAMTRESS</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MISTY HARBOUR CLOTHES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MOSES GHOLSEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY N. CLARK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES HARVELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4632 MARBLE HALL ROAD BALTO. MD. 21239</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CENTER STAR CHURCH 4/20/95</b>		20c. LOCATION — City or Town, State <b>DINWIDDIE, VIRGINIA</b>		20d. DATE <b>4/20/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Diabetes Mellitus</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic renal failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. D. Sokolow, M.D. Attending Physician</i>				29c. LICENSE NUMBER <b>D26534</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. D. Sokolow, MD 301 St. Paul Place Baltimore MD 21202</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>George McClean Heikel</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>14</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>0705 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>220-07-0885</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug. 12, 1916</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Church Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore City</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>4700 Harford Road</u>	
10f. ZIP CODE <u>21214</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>Unknown</u> College (1-4 or 5+) <u></u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Riveter</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Airline Manufacturer</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Unknown</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Edward James Wilkowski</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4117 Littletown Pike, Westminster, Maryland 21158</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Garrison Forest VA Cemetery 4/18/95</u>		20c. LOCATION — City or Town, State <u>Owings Mills, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kathleen M. Murphy</u>				22. NAME AND ADDRESS OF FACILITY <u>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Severe Dehydration</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Approximate Interval Between Onset and Death <u>few days</u> <u>few days</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Multiple infected decubiti</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. Navarro</u> <u>Med. Specialist</u>				29c. LICENSE NUMBER <u>D40356</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 14, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>D. NAVARRO</u> <u>100 N. Broadway, Baltimore MD. 21231</u>							
31. DATE FILED (Month, Day, Year) <u>APR 17 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Anderson</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.



95 11486

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Lloyd Ickes Jr.				2. DATE OF DEATH MONTH 4 DAY 14 YEAR 95		3. TIME OF DEATH 8 A M	
4. SOCIAL SECURITY NUMBER 129-14-1700		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/4/21	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 1111 Park Ave Apt 1606 Sutton Place		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH NA				10a. STATE Maryland		10b. COUNTY 11A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1111 Park Ave Apt 1606 Sutton Place	
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vocal Music Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) John Lloyd Ickes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Mary Feather			
19a. INFORMANT'S NAME (Type/Print) Joseph R. Clodfelter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Park Ave. Apt 1606 Sutton Place			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pavia Cemetery April 18, 1995		20c. LOCATION — City or Town, State Pavia, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>K. Craig Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Ave Catonsville, Maryland 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pulmonary Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Lloyd Ickes Jr.</i>				29c. LICENSE NUMBER D23829		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Lloyd Ickes Jr.</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, II, 27, PER MEO FILM G-722 4/17/95 t.t

95 11487

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY JAMISON</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>28</b> YEAR <b>95</b>		3. TIME OF DEATH <b>4:34 P.M.</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>50</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>JULY 8, 1995</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HARBOR HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTO. CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTO. CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2229 SIDNEY AVE.</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ANDREW R. SHORTS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMILY ADAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EMILY SHORTS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2229 SIDNEY AVE. BALTO. MD 21230</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEM. 4/5/95</b>		DATE		20c. LOCATION — City or Town, State <b>BALTO. MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>FATTY LIVER</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 29, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARY JAMISON A. KOREN 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 1 7 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN C. JESSEN, Jr.</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:55A</b>	
4. SOCIAL SECURITY NUMBER <b>212-28-0742</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 7, 1930</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1503 North Rolling Road</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Roadman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore County</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John C. Jessen, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Orem</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Dorothy Ridgley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1503 North Rolling Road Catonsville, MD 21228</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Services 4/18</b>		20c. LOCATION — City or Town, State <b>Hampstead, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John Arnold</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Right Lung pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypoxaemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Anasarca</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Renal failure</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>H. K. Osei MD</b>				29c. LICENSE NUMBER <b>D43750</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HENRY K. OSEI NORTHWEST HOSPITAL BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Arnold</b>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

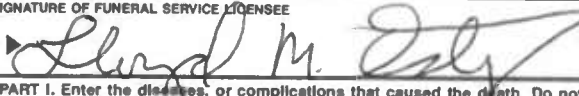
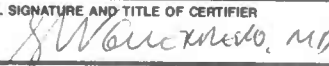

TO BE COMPLETED BY FUNERAL DIRECTOR



95 11489

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edith L. Jett</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:30 A</b>	
4. SOCIAL SECURITY NUMBER <b>278-42-5922</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/16/44</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>CITY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>940 STODDARD ST.</b>			
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>AMERICAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CALVIN JOHNSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDITH JOHNSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CAROLYN V. WEEMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4616 MARBLE HALL RD, BALTIMORE, MARYLAND</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY 4/15/95</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>				Approximate Interval Between Onset and Death <b>unknown</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Superior Vena Cava Occlusion, Diabetes Obesity</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Emmanuel Guerrero, M.D. c/o Maryland General Hospital</b>		29c. LICENSE NUMBER <b>89189</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 10, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Emmanuel Guerrero, M.D. c/o Maryland General Hospital</b>		31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 11490

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Anna Kalminzer</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>7</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>08:05 P M</i>	
4. SOCIAL SECURITY NUMBER <i>217 07 9744</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5-19-18</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>na</i>	
RESIDENCE OF DECEDENT				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>2525 W. Belvedere Avenue</i>				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>in state removal</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655 W. Baltimore St, Balto, MD 21201</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Anemia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Malnutrition, Pericardial Effusion</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric V. Jackson Intern</i>				29c. LICENSE NUMBER <i>AS2402321EJ9829</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 7, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Eric V. Jackson - Sinai Hospital of Baltimore</i>							
31. DATE FILED (Month, Day, Year) <i>April 17, 1995</i>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item # 6 Film # g 722 4-17-95 N.A. Per Funeral home

95 11491

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AYIGUAYE JAMAL KEBE				2. DATE OF DEATH MONTH DAY YEAR APRIL 12 95		3. TIME OF DEATH 3:58 A.M.							
4. SOCIAL SECURITY NUMBER 091-54-1686		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 26 - 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 3, 1969		8. BIRTHPLACE (State or Foreign Country) New York					
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A						
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION N/A			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER 9F NORHAM COURT				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOOD SERVICE		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN							
17. FATHER'S NAME (First, Middle, Last) Philip B. Kebe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice McMillan									
19a. INFORMANT'S NAME (Type/Print) Beatrice and Philip Kebe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253-27 Craft Avenue, Rosedale, New York 11422									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) CALVARY CEMETERY		OATE 4/17		20c. LOCATION — City or Town, State WOODSIDE, NEW YORK							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara A. Brown</i>				22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gun shot wounds with complications DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-9-95		28b. TIME OF INJURY 0145 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1000 Greenmont ave Balt.									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R Fowler</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11492

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Isaac Keaton</u>				2. DATE OF DEATH MONTH <u>04</u> DAY <u>11</u> YEAR <u>95</u>		3. TIME OF DEATH <u>1840</u> M	
4. SOCIAL SECURITY NUMBER <u>215-16-2531</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>March 16, 1919</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Ga</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Liberty Medical Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto</u>		9c. COUNTY OF DEATH <u>NA</u>	
10a. STATE <u>Md</u>		10b. COUNTY <u>NA</u>		10c. CITY, TOWN OR LOCATION <u>Balto</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3718 Yosemite Ave</u>				10f. ZIP CODE <u>21215</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>NA</u> College (1-4 or 5+) <u>NA</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Laborer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Merchant Sea Man</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Albert Keaton</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Bessie Mae Brown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Terry Keaton</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3718 Yosemite Ave Balto, Md 21215</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Cedar Hill Cem</u>		DATE <u>4/11/95</u>		20c. LOCATION — City or Town, State <u>Anne Arundel Co, Md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Thyris B. Scott</u>				22. NAME AND ADDRESS OF FACILITY <u>Marby F. H. West</u> <u>4300 Wabash Ave Balto, Md 21215</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John R. Hill, MD</u>				29c. LICENSE NUMBER <u>D41699</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 13, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Edna R Hill, MD 2600 Livery Heights Ave, Balto, MD 21215</u>							
31. DATE FILED (Month, Day, Year) <u>APR 17 1995</u>				32. REGISTRAR'S SIGNATURE <u>John R. Hill</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11493

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Frederica Kirchner</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4-05-1995</b>		3. TIME OF DEATH <b>11 A M</b>	
4. SOCIAL SECURITY NUMBER <b>464-05-8411</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-02-1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Florida</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Roland Park Place</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Roland Park Place</b>	
10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>NA</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>NA</b>		17. FATHER'S NAME (First, Middle, Last) <b>Frank Mosher</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Arminta Smith</b>		19a. INFORMANT'S NAME (Type/Print) <b>Walther Kirchner</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>830 W. 40th St. Balto., MD 21211</b>		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Quaker Cemetery</b>		20c. LOCATION — City or Town, State <b>Princeton, NJ</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Susan Henss Carpenter</i>		22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home</b> <b>3631 Falls Road Balto., MD 21211</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ADENOCARCINOMA LIVER</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <b>2-3 months</b>		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Daniel Sapir</i>	
29c. LICENSE NUMBER <b>010670</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Daniel Sapir 10755 Falls Road Suite 320</b>		31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>	
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>KNIGHT, DONALD</u> Donald Knight				2. DATE OF DEATH MONTH <u>4</u> DAY <u>10</u> YEAR <u>95</u>		3. TIME OF DEATH <u>12155P</u>	
4. SOCIAL SECURITY NUMBER <u>212-74-0149</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>35</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>7/2/59</u>	
8. BIRTHPLACE (State or Foreign Country) <u>BALTIMORE, MD.</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>MERCY HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH <u>CITY</u>	
10a. STATE <u>MARYLAND</u>				10b. COUNTY <u>CITY</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>1058 ARGYLE AVE.</u>				10f. ZIP CODE <u>21201</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <u>AFR. AMERICAN</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>POTOMAC PHYSICIANS</u>		16b. KIND OF BUSINESS/INDUSTRY <u>UNKNOWN</u>			
17. FATHER'S NAME (First, Middle, Last) <u>KENNETH KNIGHT</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ANNIE MAE KNIGHT</u>			
19a. INFORMANT'S NAME (Type/Print) <u>GLORIA KNIGHT</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1058 ARGYLE AVE. BALTIMORE, MARYLAND 21201</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>WESTERN STAR CEMETERY 4/14/95</u>		20c. LOCATION — City or Town, State <u>CATONSVILLE, MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>ESTEP BROTHERS FUNERAL HOME P.A.</u> <u>1300 EUTAW PLACE, BALTIMORE, MD. 21217</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>sepsis</u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>AIDS</u> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Ernest Sneed MD</u>				29c. LICENSE NUMBER <u>046039</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/10/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ERNEST SNEED, MD MERCY PRIMARY CARE 341 N. CALVERT ST BALTIMORE, MD #302 2120</u>							
31. DATE FILED (Month, Day, Year) <u>APR 17 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11495

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RALPH W. LONG				2. DATE OF DEATH MONTH DAY YEAR April 6, 1995				3. TIME OF DEATH 18:05 p.m.					
4. SOCIAL SECURITY NUMBER 233-70-0131		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 1, 1945		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Shock Trauma Ctr.-Univ. of Md.						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH n/a			
RESIDENCE OF DECEDENT													
10a. STATE West VA		10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Springfield				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER Camp Cliffside Rd.						10f. ZIP CODE 26763				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1965-1967		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer				16b. KIND OF BUSINESS/INDUSTRY Chicken Factory					
17. FATHER'S NAME (First, Middle, Last) Ralph Garland Long						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Virginia Sirk							
19a. INFORMANT'S NAME (Type/Print) Nichole Wigfield						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 86, Box 135C-Ft. Ashby, WV 26719							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Branch Mountain Cem. 4-9-95				20c. LOCATION — City or Town, State Three Churches, WV					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wendy Upchurch						22. NAME AND ADDRESS OF FACILITY Ft. Ashby Funeral Home, Inc. P.O. Box 1260-Ft. Ashby, WV 26719							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO RESPIRATORY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): c. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death													
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 4/01/95		28b. TIME OF INJURY 5:50 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED MOTOR VEHICLE ACCIDENT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Rt 29 Springfield, West Virginia							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER S. Reddy MD						29c. LICENSE NUMBER D46531				29d. DATE SIGNED (Month, Day, Year) 4/6/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sujatha Reddy, M.D. Shock Trauma Ctr. 22 South Greene St. Baltimore, Md. 21201													
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11496

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joyce Katherine Lambrose</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>11</i> , YEAR <i>1995</i>		3. TIME OF DEATH <i>10:15 P</i> M	
4. SOCIAL SECURITY NUMBER <i>514-32-7246</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 7, 1924</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Tennessee</i>				9a. FACILITY NAME (If not institution, give street and number) <i>1049 North Caroline Street</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Dundalk</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>2217 Searles Road</i>	
10f. ZIP CODE <i>21222</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 Years</i> College (1-4 or 5+) <i>College</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Restaurant Service</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Food Industry</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Jasper Haun</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Stella Phillips</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Joann Matherly</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2217 Searles Road Dundalk, Maryland 21222</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Meadowridge Mem. Ph. Cem. 4/13/95 Dorsey, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Possible Aortic MI</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>of Systemic Hypertension</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>of Cerebral</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>of Esophagus</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>Nov. 7, 1924</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D14221</i>			
29d. DATE SIGNED (Month, Day, Year) <i>4.12.95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>T. A. Brown, 223 E. Bow, BALTIMORE, MD 21221</i>			
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James M. Lee</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 16, 1995</b>		3. TIME OF DEATH <b>12:45AM</b>	
4. SOCIAL SECURITY NUMBER <b>229-10-4935</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 17, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2008 E. 30 TH STREET</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 TH</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CAN COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES I. LEE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE DIXON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VELMA LEE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2008 E. 30 TH STREET, BALTIMORE, MD 21218</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM. 4-20</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lee V. Holland</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH. 01101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARDS</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Aspiration Pneumonia</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>1 Day</b> <b>2 Day</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.D.</b>				29c. LICENSE NUMBER <b>AT-2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/16/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>UNION MEMORIAL HOSPITAL, BALTIMORE, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
 BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital. The funeral director must complete and file the certificate with the State Department of Health and Mental Hygiene within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROGER LAWRENCE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>15</b> YEAR <b>95</b>		3. TIME OF DEATH <b>05:40A</b>	
4. SOCIAL SECURITY NUMBER <b>219-38-8920</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 10 41</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>NA</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>903 Lenton Avenue</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NA</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Meat Cutter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Meat Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Lawrence</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Lee Stokes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Dyer Lawrence</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>903 Lenton Avenue Balto, MD 21212</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland National 4/19/95 Balto, MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Univest Funeral Home 108 West North Ave. Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>END STAGE AIDS</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. JILLAPALLI MD</b>				29c. LICENSE NUMBER <b>P 08238</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 15, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. JILLAPALLI GOOD SAMARITAN HOSPITAL, BALTIMORE MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 11499

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN - MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last) <b>SALLIE FRANCES LEWIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 15 1995</b>		3. TIME OF DEATH <b>8:16 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>401-28-3293</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 14, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Kentucky</b>				9. COUNTY OF DEATH <b>N/A</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>4705 Grindon Avenue</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Homemaker</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Gid Riddle</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nervesta Holcome</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Eugene Lewis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4705 Grindon Avenue Baltimore, Maryland 21214</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Pk. Cem. 4/18/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark T. Zavoyna</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>END STAGE ISCHEMIC CARDIOMYOPATHY</b>					
		b. <b>MULTIVESSEL CAD</b>					
		c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
		d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>CHRONIC RENAL FAILURE</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
<b>SICK SINUS SYNDROME</b>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Maya Gupta M.D.</b>				29c. LICENSE NUMBER <b>P08236</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MAYA GUPTA GOOD SAMARITAN HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Anderson-Randall</b>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2187-005

BKS

ITEM: 12. PER F.H. FILM G-726 8/30/95 t.t

95 11500

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT RICHARD MALAN</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:27 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-36-4098</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 17, 1939</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7419 BAY FRONT ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>EDGEMERE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Edgemere</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7419 Bayfront Road</b>				10f. ZIP CODE <b>21219</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>VIETNAM</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Automobile Repair</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sigmund Richard Malan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cathryn Adele Plummer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cathryn Malan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7419 Bayfront Road Edgemere, Maryland 21219</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 4/17/1995</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Atherosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 13, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1995</b>				REGISTRAR SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

